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KEEPING THE PROMISE: SITE-OF-SERVICE MEDICARE PAYMENT REFORMS

WEDNESDAY, MAY 21, 2014

House of Representatives,

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Lance, Cassidy, Guthrie, Bilirakis, Ellmers, Pallone, Schakowsky, Green, Barrow, and McKinley.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Mike Bloomquist, General Counsel; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Chris Pope, Fellow, Health; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Eddie Garcia, Democratic Professional Staff Member; Kaycee Glavich, GAO Detailee; and Amy Hall, Democratic Senior Professional Staff Member.

Mr. {Pitts.} The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today's hearing is designed to educate members on a topic that has come up repeatedly in recent years: site-neutral payments. In two recent reports, MedPAC has addressed the differences in Medicare payment rates across sites of care. MedPAC's March 2012 report recommended that payment rates for certain evaluation and management services be equal, whether these services are provided in a hospital outpatient department or in a freestanding physician office.

Currently, hospitals are reimbursed for these services under the Hospital Outpatient Prospective Payment System (HOPPS), and physicians' offices are reimbursed under the less generous Physician Fee Schedule.

In its June 2013 report, MedPAC discussed equalizing payment rates for certain services in a hospital outpatient setting to those of ambulatory surgery centers (ASCs) and reducing the gap in payment between other services. However, the Commission did not make a recommendation on payment changes. These discussions bring up a number of important

issues as it relates to the role that Medicare plays in our health care system. MedPAC has estimated that seniors could save hundreds of millions of dollars a year if a site-neutral payment system were instituted.

In addition, MedPAC cites an urgent need to address these issues because services have been migrating from physicians' offices to the usually higher-paid outpatient department setting as hospital employment of physicians has increased.

While stating the benefits of site-neutral payments and post-acute care (PAC) reform, MedPAC has also expressed some concern that these policy changes could cut access to physician services for low-income patients, noting that a stop-loss policy could protect such patients by limiting hospitals' losses of Medicare revenue. These policies have arisen as potential pay-fors for SGR reform and other health care reforms. As the subcommittee with the largest health jurisdiction of any committee in the House, we are charged with safeguarding the Medicare program and preserving it for future generations.

As such, I and Ranking Member Pallone felt it important

for the members of this subcommittee to hear the pros and cons of potential policies in this space. Two pieces of legislation are also before us for consideration today. Representatives Mike Rogers and Doris Matsui introduced H.R. 2869, a proposal that would require Medicare to pay for cancer services at the same rate regardless of the site of service. In addition, Representative McKinley has authored H.R. 4673, a bill that would combine the various post-acute care payments into one reimbursement payment or bundle.

I would like to thank all of our witnesses for being here today to educate Members on both sides of the issue.

[The prepared statement of Mr. Pitts follows:]

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[H.R. 2869 follows:]

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Mr. {Pitts.} I will yield the remainder of my time to the gentleman from Michigan, Mr. Rogers.

Mr. {Rogers.} Thank you, Mr. Chairman, for holding this important hearing on H.R. 2869, the Medicare Cancer Patient Protection Act.

The United States is home to the most effective and successful cancer care in the world, creating an environment that has resulted in the best cancer survival rates across the globe. However, in the last 5 years, a troubling change in the delivery of cancer care has begun to emerge, a change that has been directly affecting not just the continuing rise in the cost of Medicare but also the ability for cancer patients to access treatment.

Since 2008, community oncology clinics have seen the shift from physician office setting to the hospital outpatient department as a result of the flawed Medicare payment policies that reimburse hospitals at higher rates than oncology clinics for the exact same service.

Due to the significant changes in Medicare payment policies, physician practices are suffering from serious

financial difficulties and struggling to keep their doors open. These changes have serious implications on patient access, especially in rural areas, where radiation therapy is not always available through local hospitals. Patients may be forced to travel long distances to receive care, posing a considerable barrier to care for beneficiaries who require radiation treatment therapy daily for months at a time, and by the way, we have examples of those very scenarios.

Moreover, this shift in setting for cancer treatment poses a threat to the solvency of Medicare as hospital consolidation of physician practices is driving up costs for the Medicare program, and more importantly, driving up cost for cancer patients themselves. Reimbursement should be equal for the same service provided to a cancer patient regardless of whether the service is delivered in the hospital outpatient department or a physician's office.

I look forward to working with my colleagues to ensure the future of community cancer care is preserved, and Mr. Chairman, I thank you, and I thank you again for taking up and having this discussion on this very important issue, and I would yield back my time.

[The prepared statement of Mr. Rogers follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognize the ranking member of the subcommittee, Mr. Pallone, 5 minutes for an opening statement.

Mr. {Pallone.} Thank you, Chairman Pitts, and I am glad to see the committee taking interest in issues of post-acute Care reform.

For many years, there has been a lot of discussion about how we move our health care system into one of quality and efficiency. In fact, if we are going to ensure that Medicare is strong for our Nation's seniors well into the future, we must diligently evaluate how we pay doctors and how we incentivize care.

MedPAC has been reminding Congress of these issues and the need for action in this area for some time. Their work and recommendations should be a useful guide for our efforts, and I thank Mr. Miller for being here today to review MedPAC's perspectives on such reforms.

I also welcome the witnesses on the second panel, who have important perspectives to offer to these topics, and thank you all for being here today.

As you know, the Affordable Care Act recognized the need for reform in the post-acute care (PAC) setting and put in motion a number of initiatives that will build towards PAC reform. Medicare is testing a number of payment system reforms such as bundled payments, value-based purchasing and accountable care organizations that will inform and help to improve care and outcomes in this area.

We know there is a lot of variation in the quality outcomes and costs of PAC around the country. Medicare pays indiscriminately for care in the PAC setting. We don't know if one side of care is better than another for a patient with a particular condition. We don't know what combination of services produces better outcomes or even what level of services is optimal for a given condition.

Medicare spends $62 billion on post-acute care in the fee-for-service setting in 2012. That is a big price tag, so it is critical we get a handle on these issues quickly. We can't improve the accuracy and efficiency of care if we don't know what we are buying, and efforts to decrease waste in the system will fall short of our dual goals of care delivery and payment reforms.

Before we can envision a wholesale redesign of the payment system, however, we need more data. We do not have any common and comparable data across providers like skilled nursing facilities, home health agencies and others to determine which patients fare best in which settings or even what appropriate levels of care are for patients of varying acuity.

So Mr. Chairman, I commend the House Ways and Means and the Senate Finance Committees for putting out bipartisan draft legislation on that issue to get the discussion started, and I hope to engage with these colleagues as policy proposals are further considered and refined, and in fact, I think you would agree, the House Energy and Commerce Committee should play a part in that conversation as we move forward.

We also know there are efficiencies and improvements to payment accuracy that must be done and can be done now such as ensuring the current payment system is providing the right incentives for quality care rather than encouraging care delivery that maximizes profits. Our committee clearly has a role to play in advancing positive beneficiary-focused

reforms related to post-acute care for Medicare beneficiaries, and I hope that we can continue the bipartisan tone in this area and work to develop solutions in the near future.

Thank you again, Mr. Chairman, and thanks, everyone, for joining us today, and I look forward to continuing to strengthen Medicare for the future.

[The prepared statement of Mr. Pallone follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes the vice chairman of the committee, Dr. Burgess, 5 minutes for opening statement.

Dr. {Burgess.} Thank you, Mr. Chairman. Thank you for the recognition, and special acknowledgement to a physician from Texas, Dr. Barry Brooks, who has joined us in the committee before. It is at this point in the hearing where I usually offer the observation that one day it is my hope that we will have arrayed on the witness table five physicians, who will tell us how much economists ought to be paid, but until that day, we will go with what we have got. We do have doctors on the second panel, and for that, I an extremely grateful.

So we are coming up on the 50th anniversary of the enactment of Medicare, in fact, 49 years ago this summer. The practice of medicine has changed a lot since 1965. I used to tease my dad back then that they had only had two drugs back then, penicillin and cortisone, and they were interchangeable. He didn't think that was very funny either.

But the practice of medicine has changed, and so has the

Medicare benefit, and that is a good thing. Now we are asking themselves if the payment structures must also be modernized so that the dollars are spent the way they are intended, that is, efficiently and effectively. Payments to doctors' offices and hospitals are sometimes misaligned with the true cost of care. Sometimes the same services are provided to patients at significantly different rates, depending upon location, with no real difference in the quality or the outcome. Payments for patient care in inappropriate or less optimal settings, of course, can lead to higher long-term costs.

I think that one of the things on this committee we must be careful about is that we do not create a race to the bottom. It is not a question of deciding what is the LD-50 of what doctors can survive on. The lethal dose 50 is 50 percent of what doctors could live on. We are not trying to ascertain the figure. The lowest payment is not always the most appropriate payment, and we should not shy away from paying for better outcomes.

I would agree with the ranking member of the subcommittee that it is important that this committee had an

important role to play and the jurisdiction of this committee is the appropriate place for having these discussions. I know I have done significant work on the cost drivers of dual eligibles. It is important for us to guard this population by ensuring we are exercising the jurisdiction of this committee to improve care in all settings.

I thank the chairman for the recognition, and I will yield time to the gentleman from West Virginia, Mr. McKinley.

[The prepared statement of Dr. Burgess follows:]

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Mr. {McKinley.} Thank you, Mr. Chairman and Dr. Burgess, for holding this hearing on H.R. 4673.

Alarmists scare seniors by suggesting that cuts to Medicare are coming. We hear it all the time, all during the campaigns, all through sessions. I am here to say they don't have to be.

For the past 2 years, our staff has been working with various stakeholders to create a program that would make Medicare more efficient and improve health care for seniors without making cuts to provider payments.

The bill before us would do just that. This bill develops a model for post-acute care services, which will increase efficiency, encourage more choice and personalize care for patients and offer significant savings to the program in the process. Estimates by independent experts have determined that this bill could save as much as $85 to $100 billion. We are not cutting funding for Medicare. We are encouraging efficiency in services and programs that are more patient-centered.

Similar models have already been developed for primary

care that has saved 24 percent using efficiency models. By improving our efficiency, we will strengthen the Medicare program without cuts.

So I have already suggested that we need to study this issue further. We have had plenty of studies. In my 4 years in Congress, this issue has been hanging for 4 years and we keep talking about studying it. It is time we do something about it. It is time to paint or get off the ladder.

Again, thank you, Mr. Chairman, for this opportunity, and I yield back my time.

[The prepared statement of Mr. McKinley follows:]

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Mr. {Pitts.} The chair thanks the gentleman, and that concludes the opening statements. All members' opening statements will be made part of the record.

We have two panels. Before we do that, I would ask for unanimous consent to include the following statements for today's hearing record from the AMAC, that's the Association of Mature American Citizens; from the AAFP, the American Academy of Family Physicians; the AOPA, the American Orthotics and Prosthetics Association; from NAHC, the National Association for Home Care and Hospice; and a collective cardiology letter on behalf of the ASES, the American Society of Echocardiography; the ASNC, the American Society of Nuclear Cardiology; and the CAA, the Cardiology Advocacy Alliance; and the Premier Health Care Alliance. Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} Did you have a UC request?

Mr. {Pallone.} Mr. Chairman, I would ask unanimous consent to include this A. Dobson/DaVanzo study titled Assessment of Patient Outcomes.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} Dr. Burgess, do you have a UC request?

Dr. {Burgess.} Yes, Mr. Chairman, I ask unanimous consent that joint testimony of the American Society for Echocardiology, the American Society of Nuclear Cardiology and the Cardiology Advocacy Alliance be submitted for the record.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} We have two pane before us today. On our first panel, we have Mr. Mark Miller, Executive Director of the Medicare Payment Advisory Commission. Welcome. Thank you for coming. Your written testimony will be made part of the record, and you will be recognized for 5 minutes to summarize. So at this point, the chair recognizes Mr. Miller for 5 minutes.

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^STATEMENT OF MARK E. MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

} Mr. {Miller.} Chairman Pitts, Ranking Member Pallone, distinguished members of the committee, thank you for asking the Commission to testify today.

As you know, Congress created MedPAC to advise it on Medicare issues, and today I have been asked to comment on site-neutral and other payment reforms for post-acute care in ambulatory settings.

The Commission's work in all instances is guided by three principles: to assure that beneficiaries have access to high-quality, coordinated care; to protect the taxpayers' dollars and to pay providers and plans in a way to accomplish these goals.

First, some of the problems that we face. Fee-for-service encourages fragmented care because we pay on the basis of location or provider rather than the beneficiary's episodes of needs. Fee-for-service also encourages high volume of service. We know that Medicare payment rates send

signals, and if they are set too high or constructed inconsistently across setting, they can result in patient selection or care patterns that focus on revenue rather than patient needs.

Post-acute care has an additional issue. The clinical guidelines regarding when a service is needed are often poorly defined and it is hard to know when an episode should begin and when an episode should end.

With respect to ambulatory care, the last few years of data shows that hospitals are aggressively purchasing physician practices, and the Commission is concerned that part of the motivation is that they can bill for the same service at a higher hospital payment rate resulting in more trust fund expenditures and higher out-of-pocket for the beneficiary but no change in the service provided.

So what has the Commission's guidance been? In the short run, in focusing in some instances or in a lot of instances on fee-for-service, the Commission would set all fee-for-service payment rates to reflect the cost of the efficient provider. This protects the taxpayer and also protects beneficiaries' premiums that support the program.

Of particularly urgent attention are the very high rates in home health and skilled nursing facility settings that have been set high for over a decade. The Commission would set fee-for-service payment rates to be the same or similar for similar patients and similar services. This protects the taxpayer, and again, if there is cost-sharing, it protects the beneficiaries' out-of-pocket.

As part of a broader recommendation on hospitals that included an update, the Commission recommended setting payment rates for selected patients the same for long-term-care hospitals and acute-care hospitals and also recommended that payment rates for a selected set of outpatient services be set equal to or near the physician fee schedule.

In order to protect the hospital's core mission, these services were chosen because they are frequently done in a physician's office, they are not part of the hospital's emergency standby services, and they are used by patients with comparable risk profiles.

Just focusing on three services. If continued migration that we see in the data now, or if migration continues as we see in the data now, by 2021, the program will be paying $2

billion more on an annual basis for just these three services, of which $500 million would be paid by the beneficiary.

The Commission is also exploring policies to normalize payment rates between skilled nursing facilities and inpatient rehab facilities. That work as developmental and will be published in the June report, but I am happy to take questions on it.

We have also been concerned that the payment systems are set to encourage patient selection. We have longstanding recommendations in skilled nursing facilities and home health settings to take down the incentives to see physical-rehab patient and avoid complex medical patients. We think this protects the beneficiary against patient selection and it protects providers that take the more complex patients.

The Commission would also create policies to encourage coordination. We have recommended penalties for hospitals, skilled nursing facilities and home health agencies that have excessive readmission rates. This protects the beneficiary by encouraging care coordination and of course the taxpayer from paying for unnecessary care.

In the longer run, the Commission has called on CMS to create pilot projects to develop various bundling payment strategies for acute and post-acute care and has called for the development and implementation of a common assessment for post-acute care. This would allow us to consistently assess patient needs, to track their change in functional status and quality, and to move towards a unified payment system on the post-acute care side. Beyond fee-for-service, a well-functioning managed care program and initiatives like the accountable care organizations can also create incentives to avoid unnecessary volume and coordinate services for providers. The Commission has a broad range of guidance on each of these, and we are willing to take questions on that as well.

In closing, the Commission has consistently tried to make policy recommendations that assure beneficiary access to coordinated care at a price that the taxpayer can afford.

I appreciate your attention and I look forward to your questions.

[The prepared statement of Mr. Miller follows:]

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Mr. {Pitts.} The chair thanks the gentleman. I will begin the questioning, and recognize myself for 5 minutes for that purpose.

Mr. Miller, some have proposed that post-acute care bundling reforms are premature and should not even be considered by Congress until such time as a standardized assessment tool is created and data collection is complete. Others have pointed to the fact that such perfecting of data collection could take a decade or more, and even then, such an assessment will need to be refined. Do you agree with the notion that Congressional consideration of bundling should only occur after an assessment tool has been created and sufficient data collected, or can both be done concurrently?

Mr. {Miller.} Okay. I think the Commission's view on this works as follows. I think there is a very strong consensus and a recommendation that we need a common assessment instrument. We think that that is a lynchpin to improving both our measurement and payment and organization and coordination over the long haul. So there is no question that should happen. We have made recommendations. We have

given a timeline. We have talked about an instrument. And just for the record, we have been pushing for this for over a decade, so I have got to make sure that I say that.

On bundling, I think the Commission believes that bundling is a viable option and is one that should be pursued, but there is a large set of technical issues that the Commission went back and forth on, and I can take you through some of that but we will see where you want to go here, and I think their view is that there should be experimentation, which is occurring now, and to see which of the models tend to jell and work best for both the beneficiary and the program. So I guess what I am saying to you is, we should be pursuing both.

Mr. {Pitts.} All right. Medicare payments are a huge influence on the health care industry, often serving as a baseline for negotiations between hospitals and private insurance. Do private payers mimic Medicare site-of-service reimbursement disparities?

Mr. {Miller.} Okay. A couple things here. It is correct that you find the same phenomenon in the private sector as you find in Medicare where if you pay for a

similar, or if you see a similar system or service in the hospital setting, it is usually paid higher by private insurance. I think there is more than--there is more to that than just the notion that Medicare does it, so too does the private sector.

Over the last several years, the private sector and hospital systems have become much more consolidated and they are able to extract higher prices in their negotiations with insurers, and that certainly contributes to the higher prices that you see in the hospital setting versus other settings. So I don't think it is just simply mimicking Medicare but the same phenomenon is observed in the private sector.

Mr. {Pitts.} Do private insurers obtain similar discounts for care that is provided through physician offices and ambulatory surgery centers?

Mr. {Miller.} I am just going to use a slightly different word. I think what you will see in the private sector is that the payment rates in ambulatory centers and physician offices tend to be lower than the hospital. Whether those are extracted discounts is just sort of a terminology point. I think it is true that they have lower

rates in ambulatory surgery centers and the physician's office for the same service relative to the hospital.

Mr. {Pitts.} Have any private insurers adopted site-neutral payment policies similar to the recommendations that MedPAC has made to Congress?

Mr. {Miller.} I don't have data, and, you know, really rigorous information on this point. What I can point you to, and I have certainly talked to the committee staffs about this, there is widespread newspaper reports where privately insured folks are showing up at the physician's office after a physician has transferred to a hospital ownership and seeing their cost-sharing go up, you know, significantly, and this has been reported on a widespread basis, and what we have heard in discussion, but there is not a lot of science behind this, is there have been some private insurers have refused to pay the additional facility fee for regular office visits in the hospital setting. So I don't want to overplay that but that is more anecdotal and what we are reading and hearing in discussion.

Mr. {Pitts.} The respected journal, Health Affairs, this week released a study finding that hospital ownership of

physician practices is associated with higher prices and spending. Can you comment on how Medicare's payment differentials might have spillover effects to the private sector and health system?

Mr. {Miller.} Again there, I think part of what is going on, and I did look at that when it came along but I am sure I can dredge it right back up, but I think part of the explanation there is some of the consolidation and the ability of hospital systems on the private side to extract higher prices. I think what you are seeing both in the private and in the Medicare payments is this ability to arbitrage, to say if I can move a practice into the billing stream for the hospital side, both for private insurance and for Medicare, the hospital will get more revenue. So that certainly seems to be going on, and what we are concerned about is, while it is not the only reason that a hospital would purchase a physician practice, because there are other motivations for doing that, the fact that Medicare's payments are so much higher on the hospital side certainly encourages the migration, and we are seeing a fair amount of it.

Mr. {Pitts.} The chair thanks the gentleman and now

recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. {Pallone.} Thank you, Mr. Chairman.

Mr. Miller, I am amazed by how much variation exists in the care provided in the post-acute setting. There is no uniform assessment of where a patient should go following a hospital stay. Does a patient with a hip replacement fare better in a skilled nursing facility or home health agency? We don't really know. And how much post-acute care does a typical hip replacement patient need? We don't really know. So given that the Medicare program spent $62 billion on post-acute care in 2012, I am amazed we don't have better information about patient outcomes, service use or quality of care.

So my question is, does MedPAC view this as a problem, and what do we do about that and how can we quickly move to a place where we have info to know what kind of care is being provided?

Mr. {Miller.} Okay. You are right. There is significant geographic variation, or significant variation, not even just geographic, even with the same marketplace and

the amount of post-acute care. I think there is a couple issues there, the one that you referred to, which I will come right back, and the notion that it is hard to define in many instances, you know, the amount of post-acute care that a patient should get, when do you stop rehab, you know, for some--

Mr. {Pallone.} I agree.

Mr. {Miller.} --and where--

Mr. {Pallone.} I am going to answer the question myself.

Mr. {Miller.} So the Commission, as I said, a little bit in my opening comments, many years ago said we need a common assessment instrument. It took a long time, but the Congress then called on CMS to develop an instrument and to test it, which they did through the care demonstration, and that instrument now exists. We believe, and we have made a recommendation along these lines, you can take the elements from that instrument--doesn't have to be the whole, giant thing--put them into each of the current collection instruments that exist for SNF, home health, require one for long-term-care hospitals and then you will be able to sweep

up that information across the settings and be able to start making judgments about does a patient have a better outcome in one setting versus another, what is the average resources, the very things you are saying, for hip replacement as the case may be. We laid out a 3-year process to get that information integrated into the collection instruments and then have a product. So yes, that is what we should be doing.

Mr. {Pallone.} And, you know, I do think that is important to have but, I mean, it is always going to be individual case too, though, obviously.

There have been a number of proposals to bundle payments for post-acute care, and the President's budget proposed to bundle 50 percent of PAC spending by 2019. Mr. McKinley is working on a bill that would bundle payments for care and pay a reduced rate. But how can we develop a bundled payment rate or develop the items that go into a bundle or develop appropriate risk adjustment? I mean, it is obvious if we don't have basic data, that is going to be difficult, so that is obviously why you think the data is important.

Mr. {Miller.} And in some ways, this is this question

that came up, is it an either-other type of thing, and I think the urgency in some of what you have laid out at the beginning really requires that we proceed on both tracks. So let us just say that there is a bundle--there is a lot of complexity in assembling a bundle but just for half a second let us pretend that we have some sense of what that is. One way that you can kind of mitigate against the fact that you don't have ideal information is, you could continue to use a fee-for-service model underneath a set platform, so you don't have a stinting incentive. In order to get paid, the person has to provide the services. You put a small portion of the payment, let us just for discussion call it 5 percent, and then you do have measures, and the Commission had worked with these and there are others out there on things like avoiding the emergency room, avoiding the hospital and community discharge and say okay, those are the three outcomes we are looking for, here is the block of dollars and then get providers who are willing to take that risk and manage the patient through that episode, and that is imperfect information but we are assuming that the provider will have tools to have more accurate information on the ground while

the program is developing through this unified assessment instrument.

Mr. {Pallone.} I know we are almost out of time, but could you just quickly--

Mr. {Miller.} Sorry about that.

Mr. {Pallone.} --talk about the stinting or potential dangers in the bundled payment or capitated payment design?

Mr. {Miller.} It is always an issue when you--I mean, you know, fee-for-service has the issues that I have raised, fragmentation and generation of volume. Any time you go to an episode, capitated, you know, whatever the case may be, you have the reverse problem where you create the incentive to under-provide. You have to either have a mechanism that encourages that like paying on a service basis underneath a cap or you have to have quality--and you have to have quality measures that say to the provider, you are not going to get paid or not get your withhold back or whatever the case may be unless these quality metrics are met. But it is decidedly an issue. It is not something to be brushed past.

Mr. {Pallone.} All right. Thanks a lot.

Thanks, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for questions.

Dr. {Burgess.} Thank you, Mr. Chairman, and Mr. Miller, thank you for being here this morning.

In the report from June of 2013, you discussed the increase hospital consolidation, particularly in the cardiology space. Has MedPAC seen this trend in other specialties?

Mr. {Miller.} I am not sure I can break it down for you by specialty, but yes, we have seen it in other services, not just simply cardiology services. But yes, we have seen it in other services.

Dr. {Burgess.} And those other services, examples of those would be?

Mr. {Miller.} You know, certainly the E&M, you know, basic evaluation and management visits are shifting. I guess some of the ones that immediately come to mind are cardiology, echocardiograms. There are probably some other examples I can't dredge up at the moment.

Dr. {Burgess.} What about clinical oncology?

Mr. {Miller.} Okay. So in that, you know, obviously understanding that there was going to be a hearing, we looked at it a little bit, and just before I answer, yes, there are a few oncology--when we went through our recommendations that were in the March 2014 report, and we have the set of services that we are saying should be set to the physician fee schedule rate, there are a few services in there, two, three services, that seem to be related to oncology but we didn't approach it as a specialty or a service line approach. We had a set of criteria and said if services meet this criteria--I won't drag you through it unless you want to hear it--then the service was put into the policy, but we didn't approach it as oncology, cardiology.

Dr. {Burgess.} Could you perhaps that in writing? I will ask the question for a written response.

Mr. {Miller.} Yes.

Dr. {Burgess.} I actually would be interested in the thought process in going through that, but we don't need to go into that now.

Have you looked at what happens to patient access and costs with hospital acquisitions around different

specialties?

Mr. {Miller.} Well, what we look at every year, both in the hospital setting and in the physician setting and in every other setting that we look at, we look at access and utilization. Now, if your point is--and it may be--well, what happens to access if we get this migration into the hospital for oncology services, we haven't looked at that recently. We looked at it several years ago. We haven't looked at that specific phenomenon. But we broadly look at access year and report to the Congress.

Dr. {Burgess.} When you say several years ago, like how many years ago?

Mr. {Miller.} Longer than I would report the results.

Dr. {Burgess.} So--

Mr. {Miller.} Eight.

Dr. {Burgess.} So prior to the passage of the Affordable Care Act?

Mr. {Miller.} One more time?

Dr. {Burgess.} Prior to the passage of the Affordable Care Act?

Mr. {Miller.} Yes.

Dr. {Burgess.} So have done any kind of estimate on the return on investment to this trend? What are the costs/benefits as far as patients and their access to care, the cost-benefit analysis for this consolidation?

Mr. {Miller.} So the migration from the physicians' offices to the hospital?

Dr. {Burgess.} Correct.

Mr. {Miller.} At least for the services that we looked at and met our criteria, which I realize we haven't had that conversation, for about 66 of them that met our criteria, and if you look at that, it is about a billion dollars of program spend and about let us call it $200 million in beneficiary out-of-pocket that is being incurred because these are being migrated. We have not seen access issues but again, we haven't gone in by service line or specialty to see that, but we have not seen access issues.

Dr. {Burgess.} But there is a dollar impact?

Mr. {Miller.} Oh, yeah, and I tried to point that out in my 5 minutes.

Dr. {Burgess.} And one of the reasons I am concerned about this, and I don't have the article in front of me but I

think it was in August of 2011 in the Annals of Internal Medicine, if I recall correctly, Ezekiel Emmanuel wrote an article about the fact that doctors really shouldn't fight the concept of being employed by an entity, presumably a hospital or insurance company or even a governmental entity, that this would be a better way to deliver care. It frees the doctors from having to worry about the vagaries of running a business, but because of the Affordable Care Act, there is this pressure for consolidation, and I ask myself all the time, just from a professional standpoint, is this a good thing or a bad thing. I come from a long line of a medical family, and our contract was always with the patient. Our advocacy was always supposed to be for the patient. If I work for the hospital, then suddenly that dynamic changes and I am not certain--and I can't put a dollars-and-cents figure on that. I don't sense that that necessarily is an improvement in the practice of medicine. Obviously, a philosophical article but I am concerned about the effect of consolidation cost being used as a driver.

I have got several other questions I would like to ask you, and I will submit those in writing, and the chairman

will delineate how we get those responses.

Mr. {Miller.} I see 37 seconds, so--

Dr. {Burgess.} That means I am over, but proceed. That is a surrogate endpoint.

Mr. {Miller.} Okay. I mean, one thing I would say is, I don't think the Commission is--I am sure the Commission is not making a statement about better or worse ways to organize practice. What the Commission is saying is, it shouldn't be driven by distorted prices. Those decisions should be made by a physician saying I want to practice this way or I want to practice that way or what the best episode and arrangement is for the beneficiary, and it shouldn't be just this price-driven phenomenon.

Dr. {Burgess.} And I agree with you completely.

Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. {Schakowsky.} Thank you, Mr. Chairman.

I want to talk to you about observation status and then what it means for post-acute care. This has been a huge

issue for constituents in my district who when they get to the hospital and they are put into a room think I am admitted to the hospital, and my understanding is that it is open-ended how long observation status can actually occur, and then if they end up going to a skilled nursing facility, then they find out that Medicare doesn't pay anything. They thought they were admitted to the hospital, for good reason. We find frail, elderly people sometimes with certain mental deficiencies, and if they are in the hospital and they are in the hospital a few days to assume that they are admitted to the hospital seems logical.

So we have had large numbers and dealt with CMS a lot on this question of observation status. So I wonder if you could just clarify this for me and how it impacts then the post-acute care status in terms of payment?

Mr. {Miller.} Okay. I am not as deep for this hearing as maybe on some other things.

So I think the issue that you are getting at--you tell me to redirect if we are not on the same wavelength--is that if somebody enters the hospital and ends up, let us just say for the sake of discussion, in three days of observation

care, although lots of observation stays last much less than that, then while they by all appearances to the beneficiary and their family, they have been in the hospital, they won't have qualified for the 3 days of hospitalization needed to qualify for skilled nursing care.

Ms. {Schakowsky.} That is correct.

Mr. {Miller.} I think that is the point that you are driving at.

Ms. {Schakowsky.} That is correct.

Mr. {Miller.} And I think, you know, the dilemma for the Congress is that, you know, when a beneficiary feels, and for almost all intends and purposes has been in the hospital, the concern is that they should qualify. Of course, the issue that has to be dealt with--and them I am going to get you to a happier place in just a second--the issue that has to be dealt with is, if you simply remove that 3-day requirement, the estimators, the Congressional Budget Office and folks like that, believe that the skilled nursing facilities will start to get community admits and then the costs will go up significantly. So there is an issue that gets kind of enjoined there.

But the happier place perhaps--

Ms. {Schakowsky.} I don't understand what you just said, that they will get community admissions.

Mr. {Miller.} So if you say to--if you were today--and this is something you should check--this is what I understand, and I am a little bit off base, but this is what I understand. If you said today there is no 3-day requirement to stay in the hospital to go into--

Ms. {Schakowsky.} No, no, I am not saying that.

Mr. {Miller.} Well, I am just saying if you did, you would run into a cost.

Ms. {Schakowsky.} Yes, okay.

Mr. {Miller.} So there are other avenues to potentially explore here. One is--and the two discussions that--and I have some work going in the background although I haven't brought it forward yet because it is not far enough along, is looking at the inpatient hospital payment system and creating a short-stay payment so that they don't have to have this choice between observation care and short-stay inpatient stay, and then the person would come in in the inpatient and it would be classified as an inpatient stay. So there is

both an observation versus inpatient issue there and it has bearing on your skilled nursing facility question.

Ms. {Schakowsky.} Correct.

Mr. {Miller.} We are not far enough to have a nice, concrete conversation about the specifics but we are working on that.

Ms. {Schakowsky.} Okay. I think it is really important. I can't tell you how many elderly individuals and couples have just been astonished at being--they are not really admitted to the hospital. It just doesn't make sense.

Mr. {Miller.} I hope you are hearing that we are taking this seriously because nothing I have said should have given you anything other than that.

Ms. {Schakowsky.} And is there any timeline built into this?

Mr. {Miller.} You know, we are working with data, we are talking to hospitals. These are kind of messy issues. There is a rack auditor issue kind of mixed in there as well. We are working on it, is the best I can tell you at this point.

Ms. {Schakowsky.} Let me just submit for the record,

there is a question I want submitted that deals with post-acute providers' high profit margins that I want to get to you as well. Thank you.

Mr. {Miller.} I would be happy to talk about that.

Mr. {Pitts.} The chair thanks the gentlelady and now recognizes the gentleman, Mr. Rogers, 5 minutes for questions.

Mr. {Rogers.} Thank you very much.

Thank you, Director, for being here. Over the last 5 years, 47 community practices have started referring all of their patients elsewhere for treatment. Two hundred and forty-one oncology office locations have closed and 392 oncology groups have entered into an employment or professional services agreement with a hospital. That is a fairly staggering shift in 5 years. What would you attribute that significant shift toward a hospital setting?

Mr. {Miller.} You know, with respect to oncology, I am a little bit of a deficit here to give you the specifics related to that. The broader trend that we are seeing we think are the trends that I have been speaking to up to this point. There is a lot of consolidation out there. I think

the hospital's motivations come in a couple of varieties. There is this notion of building systems and coordinating care, which may be a good motivation. There is capturing referrals, and, to the extent to that the Medicare and the private sector pays more when you make that jump, then there is that motivation.

On the physician side, and this goes to some of what Mr. Burgess is saying, I hear both kinds of conversations, ones that are ``I am very upset by this trend and I don't want it to happen,'' and other physicians who say this actually frees me up to kind of focus on care, and I am not saying that is the oncology argument but I have heard that from other practices. I think this is kind of a complex set of currents running in both directions.

Mr. {Rogers.} Although in a market economy, if the hospitals pay more for exactly the same services, it is pretty hard to argue that that isn't a significant factor.

Mr. {Miller.} And you do hear us saying that is what we--

Mr. {Rogers.} I just wanted to clarify that number because I was staggered by it. A $1 billion increase, if I

heard you correctly, from that migration to the hospital setting of which $200 million is borne by the hospital--or excuse me--by the patient. Did I understand that correctly?

Mr. {Miller.} Yes, and just to clarify, for the 66 services that we have identified which may or may not encumber the ones that you are referring to, we think on an annual basis we are talking about a billion dollars, and just for round numbers, let us say the beneficiary carrying 200.

Mr. {Rogers.} That is a significant cost increase for the patient, is it not?

Mr. {Miller.} Yes, and--

Mr. {Rogers.} It is a 20 percent increase.

Mr. {Miller.} Yes. There are examples of these differences. For example, for cataract surgery, if you get it in a physician's office, the copayment is $195. If you go into the hospital, it is $490. That is the beneficiary's--

Mr. {Rogers.} And 20 percent of that increase, according to your numbers, would be borne by the patient?

Mr. {Miller.} No, that is the beneficiary's increase.

Mr. {Rogers.} That is just the beneficiary's increase?

Mr. {Miller.} The program increase goes from about

$1,000 to about $1,800 on the program side.

Mr. {Rogers.} That is a significant out-of-pocket increase for those patients, is it not? So if you look at something like--let us talk about some kind of radiation treatment, somewhere between 6 and 8 weeks. So we have had this major displacement of at least places that are convenient for treatment, a daily transportation for the 6 to 8 weeks for these treatments and a roughly 20 percent increase. Someone has to tell me why that is good for the patient.

Mr. {Miller.} Again, I can't speak to your very specific oncology examples. Our concern is motivated both by the program dollar and beneficiaries out-of-pocket.

Mr. {Rogers.} And I would hope that you would consider travel times. When you are getting radiation treatment, obviously I am specific to oncology here, but you are already tested to the limit, and increased commute times and pay more money doesn't seem like a good idea for care to me.

I mean, have you done anything that shows a benefit to the patient from moving to hospitals? Is there any white paper I can look at? Is there anything that tells me that

this is a good idea for people like cancer patients, or in your case, cataract patients?

Mr. {Miller.} I want to answer this carefully. We have not done anything, which doesn't mean it doesn't exist. It is just that we haven't done anything. So I am unable to point you to something but it is not because I know that is the answer. It is just because we haven't done anything.

Mr. {Rogers.} I thank you, and my time is running out, but Mr. Chairman, thanks for having this hearing. I think just the fact that we pointed out the significant cost to patients, number one, not only in just dollars but the anxiety that comes with getting in that car and driving a greater distance just to have access to care means that we ought to do something about this yesterday. We already have lost 392 plus the 241 just oncology, just oncology centers are gone, and wrapped up in this system. Two hundred and forty-one just closed completely. The longer this goes, the more we will lose, the more patients that will be impacted by out-of-pocket costs, and again, all of the anxiety and trouble that is caused by greater distances is very, very troubling.

I appreciate you having this hearing. I think this has highlighted a very important issue that needs immediate attention. I yield back my time.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Murphy from Pennsylvania 5 minutes for questions.

Mr. {Murphy.} Thank you, Mr. Chairman. I want to follow up on some of the issues presented by my friend Mr. Rogers of Michigan.

So when we are looking at the out-of-pocket costs a Medicare patient may pay, they will pay a copay for some chemotherapy and other treatments, and is that a percentage basis or is it a flat dollar?

Mr. {Miller.} It is usually 20 percent just because nothing is simple. It varies a bit in the outpatient department on a percentage basis due to some very old historical issues that are being changed over time. But for purposes of conversation, think 20 percent.

Mr. {Murphy.} Okay. And rather than look at the aggregate amounts totally, so if somebody was getting some treatment at a clinic--well, those clinics that haven't

closed yet--versus at a hospital, any sense of what the comparative price would be for individual treatments in one place for another?

Mr. {Miller.} For a clinic?

Mr. {Murphy.} A clinic or a physician's office or a hospital. You know, we are talking about the differences in disparity here.

Mr. {Miller.} If I understand your question, some of the data that we have put out suggests that evaluation and management issue or a visit is paid about 80 percent more in the hospital setting. An echocardiogram is paid about 130 percent more in the hospital setting.

Mr. {Murphy.} So if they are paying 130 percent more in the hospital setting, that means the patient is paying more in the hospital setting too if they are paying 20 percent, but do you have any idea what that dollar value might be. I know it probably varies by region.

Mr. {Miller.} Well, you know, there is some adjustment for wage index and things like that but I think this is correct if you don't--I have some scribbled notes that I was writing down last night. I think, for example, on the

echocardiogram, the beneficiary's copayment goes from about $40 to $90. The program payment goes from about $150 to $360.

Mr. {Murphy.} Which is pretty significant, especially if someone is on fixed income.

Mr. {Miller.} I am sorry?

Mr. {Murphy.} If someone is on a fixed income, well, under any circumstances, and of course, if a person is chronically ill and receiving a lot of medical care, that can amount to thousands of dollars in a year.

And so let me ask you another issue too. Now, some centers have a 340B program and so they are able to obtain drugs as long as, I understand, if they are a nonprofit patient they can quality to purchase drugs on a 340B program. Am I correct?

Mr. {Miller.} There may be some more requirements than that but I will stay with you for the moment.

Mr. {Murphy.} Well, let us say a private physician's office or a for-profit clinic or something would not be able to purchase drugs on those discounts. Am I correct?

Mr. {Miller.} I am pretty sure that is correct.

Mr. {Murphy.} One of the concerns that I frequently hear about the 340B program, first of all, it is a great program. I support it strongly in many instances. But we also hear that some are claiming that there are some abuses of that program where some centers will purchase drugs at discount but then they will sell them at the markup again and get this money. Now, is that something that some of these other private clinics or physicians' offices, are they able to purchase drugs from the 340B program?

Mr. {Miller.} Again, I am not deep on this, given the subject of the hearing. I didn't study down on this one. But my sense is no, that is not available to them.

Mr. {Murphy.} So this adds another issue here. I mean, what I hear frequently across the board, hospitals and physicians saying that the reimbursement rates for mc doesn't really cover their costs sufficiently. They complain about the low reimbursement rates. But what you are telling me is that if we focus also on--if some of them also are making money on the 340B program, and maybe this is out of your wheelhouse, but that is another area of disparity if there are differences between people who generally qualify versus

those who may not qualify but the hospital is still getting some 340B money out of this.

Mr. {Miller.} To the extent that the fact set that you and I are talking about here without me doing the homework on it, yes, that would be true, and I would say to you similar to what I said to the Congresswoman over here, this is an issue that we have not come forward on because there is still a fair amount of staff work to be done, but we have started to try and look at it.

Mr. {Murphy.} We hope that is information you will provide this committee.

Let me ask one last thing then. So we have heard concerns before of people with non-insurance or Medicaid versus private insurance. The survival rates are very different for people with cancer. But that is also according to the Cancer Medicine Journal, it is due to a complex set of demographic and clinical factors of which insurance status I just a part.

But let me look at this in terms of Medicare in terms of where a person actually gets their care, a hospital base versus a physician's office. Are there differences there in

survival rates that you are aware of?

Mr. {Miller.} I have not looked at that, which doesn't mean--I don't know the answer to that question.

Mr. {Murphy.} That would be something that would be valuable for us to get to.

I thank you very much, and I yield back, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. {Green.} Thank you, Mr. Chairman, and I would like to ask unanimous consent to place in the record a written statement by Dr. Bruce Ganz, Chair of the American Medical Rehabilitation Providers Association regarding the post-acute care reforms being discussed today.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Green.} Thank you and the ranking member for holding this hearing. I want to thank Dr. Miller for your testimony.

Our district in Houston is home to world-class hospitals and community oncology centers. We know that Medicare payment rates often vary for the same service provided to similar patients in different settings such as physicians' offices, hospital outpatient departments or for specific services across any of the post-acute care settings. While at the first glance it seems unclear why Medicare would pay different rates for the same service, we have heard justifications from both sides of the debate on whether the main thing in these differential payments are to move to site-neutral payments. For example, Representative Rogers has a bill that would equalize reimbursements for oncology services received by patients in a hospital outpatient department with those by patients in freestanding oncology clinics. The hospital outpatient departments tell us that their higher rates are necessary because their additional payments help pay for the hospital standby capacity, access

to care for low-income patients, efforts to improve care coordination and community outreach. The freestanding clinics have said the payment system is inadequate, causing them to close their doors, limiting access to care for critically ill patients and increasing total costs as hospitals are buying them up.

Mr. Miller, as you represented a nonpartisan research-driven policy body, I am interested to hear your perspective on the matter. I understand that MedPAC has given a considerable amount of thought to the subject to site-neutral and establish criteria for when it is appropriate to equalize payments across settings including considering beneficiary access and cost-sharing. Could you further describe the Commission's thinking on the topic?

Mr. {Miller.} Yes, and I actually appreciate the question, and this is in some ways what Mr. Burgess and I were almost up to.

So the way the Commission has approached this in the ambulatory setting, the principal is, assuming and assuring actually that the beneficiary has access and quality, Medicare should seek the most efficient setting, and so that

is the motivation, and the other motivation is, we have seen a tremendous amount of data that suggests that it is heading out of the lower payment setting.

But by the same token, and while there are people in the hospital industry who probably are suspect, we want to be sure that the hospital's core mission, particularly for emergency room and standby services, are not undercut, and so the criteria that we worked through was, is the service provided in a physician's office frequently so it is safe to do outside of the hospital, is the risk profile of the patients the same, is the unit of payment the same, and is it not associated with emergency services, and so then using that criteria, we said what services fit this criteria. So we are not just sort of sweeping through and saying pay it all, you know, the same, we are saying you need to be careful to protect the core mission of the hospital but also undercut this incentive that is pulling things out of the physician setting and approaches the practice. So that kind of high level, that was the criteria that we were using.

And again, you know, I have gotten some other questions of what about oncology, what about cardiology. We didn't

approach it as a specialty or service line. We stepped back and said what meets these criteria and then let things hit the criteria and said okay, these are the ones that qualify.

Mr. {Green.} Has MedPAC given thought to aligning payment rates between hospital outpatient departments and physicians' offices for other types of ambulatory management, cardiac surgery? I think you answered that.

What further analysis or information would you need before being able to comment on the appropriateness of equalizing these payment rates between OPDs and the physician offices for oncology services? Are there any concerns you can share with us now?

Mr. {Miller.} I mean, what I do want to point out before I switch right back to your question is, we looked at this also for equalizing rates between ambulatory surgery centers and hospital rates for a set of surgeries that also met these criteria that I went through. On the oncology side, I am willing, as a matter of questions for the record, to try to give you a more detailed answer of what oncology services came in under our criteria and the kinds of things one might want to think about if they were to look further

into it, but I am not really tooled up to do that right this second.

Mr. {Green.} Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. {Guthrie.} Thank you, Mr. Chairman. I appreciate it. And I guess you almost got to one of the things I was thinking. You have to make sure the same person walking into an outpatient isn't the same person walking into a hospital because if you are going to do the same procedure--

Mr. {Miller.} Absolutely.

Mr. {Guthrie.} What if the person is diabetic? Therefore, they say we need to do this in the hospital so you do have paying for capacity for some availability there, so that is just something that I was thinking that you kind of addressed that before.

Mr. {Miller.} And the Commission does take that seriously, and there was statistical work done by a couple of people behind me who said do these patient profiles look statistically different than each other, and if they did,

they weren't included in the basket of services that we would focus on.

Mr. {Guthrie.} And do you think some of it could be cost shifting such as an outpatient clinic wouldn't have--they obviously don't have emergency room, and I hear, I think somebody mentioned it earlier that people come in with Medicaid and Medicare particularly don't pay the cost of--it may pay the cost of service for a cardiogram more than if you got it outpatient but it is also keeping the emergency room open. I am not saying that is the right way to do it.

Mr. {Miller.} I think I understand your question, and if not, immediately redirect because I want to use your time carefully. We also took that into consideration. We said if a service is provided in an emergency room setting on, you know, any significant basis, then again, it was out of the mix, and our point was, we don't want to undermine the core mission of the hospital to have emergency standby services. The Medicare payment rates, since those services are very--or those costs are very direct--staff, equipment, that type of thing--those are built into higher rates that go to the hospitals for those services. We share that concern. We

tried very hard to work around that and make sure we weren't undercutting that.

Mr. {Guthrie.} Okay. Thanks. And a couple of questions I wanted to ask about the--going from a lot of people in private practice settings into hospital settings. There was a Merritt Hawkins survey that asked the students in the final year of medical school. In 2001, 3 percent said they would rather work for a hospital than private practice. Now it is 32 percent. I know there are a factors but what extent do you think the Medicare practice expense payment disparities are responsible for the decline in attractiveness?

Mr. {Miller.} Okay. I think this question is much more complex, but before I blow past it, I do want to say, and I think there were some other comments along these lines, it is very hard to ignore that if a hospital is approaching a practice and saying I have, you know, revenue that I can buy out your practice and make it very lucrative to you, that is going to be important. But to the extent that we have talked to physicians, talked to hospitals, talked to folks like that, we hear a very, you know, kind of mixed story on the

part of the physicians. There does seem to be a generation of physicians who are saying care has become very complex, and I don't mean that in a negative way. It means, you know, we all have to think about the patient much further and broader than my own sets of services that I am providing. It takes more coordination, it takes more understanding of the patient's medical record, and some physicians will say a larger organization that will take that overhead off of my hands and allow me just to focus on the care is where I want to be, and by the way, I would like some predictable hours and that type of thing. And then you run into physicians who are saying this is the wrong direction to go, I want to run my own practice. So I think these currents are more complex than any one factor, but I don't think we should dismiss the notion that either in the private sector or Medicare if the revenues are there, then it is going to be hard to say no to them.

Mr. {Guthrie.} That is a good question, it leads into my next one, because you said whether Medicare or private sector. Does the private sector, private payers mimic the Medicare site-of-service disparity of payments?

Mr. {Miller.} I wouldn't use the word ``mimic'' but the outcome is the same. It is generally true that the private sector pays more in those settings than in the physician setting.

Mr. {Guthrie.} So they get similar discounts between hospitals and ambulatory areas?

Mr. {Miller.} There are similar price differences between physician office and hospital settings--lower, higher.

Mr. {Guthrie.} Well, I appreciate that, and I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. {Ellmers.} Hi, Mr. Miller. Thank you for being with us today.

I do want to--I know some of my colleagues have asked about the 340B program, and I believe you had said that at this point it is being looked at. Is that correct, that you are not ready to kind of weigh in on it?

Mr. {Miller.} I haven't even taken the Commission

through it because the research is really still very much at the formative and staff level.

Mrs. {Ellmers.} Okay.

Mr. {Miller.} But we are not oblivious to the issue. That is the point I would like the committee to know.

Mrs. {Ellmers.} Great. Well, you know, and I will tell you, it is a concern of mine because I do believe that there is--just as you are looking into the issue, I think there is a lot of gray area there, and I think that this is one of those issues when we are looking at health care savings and dollars that are being saved, and of course, first and foremost, patient access to care, especially those who are, you know, in an economic disadvantaged situation, that these programs are very worthwhile and we need to make sure that they are sustainable. Unfortunately, I am not at this point sure that we really know where those dollars are going, and I think that is something that we need to get to the bottom of and, you know, with that, I will just follow up by saying that about a year ago, last year, Commander Pedley, the head of HRSA, had stated that she was not sure where the dollar savings, where the money was going, and I think that that is

a significant statement because if the government doesn't know--I mean, shouldn't the government know where these dollars are going and how they are being utilized?

Mr. {Miller.} I think so.

Mrs. {Ellmers.} And there again, I will just get back to the issue of--

Mr. {Miller.} But I want to assure you that we wouldn't look at that issue strictly as a savings issue. We would look at it as a program integrity issue, assurance for beneficiary access, assurance that we are paying fairly and then, you know, if that turns out that we are letting dollars go out the door that shouldn't go out the door, then that will be the outcome.

Mrs. {Ellmers.} I think, you know, from my perspective, it is an issue of, are those dollars going to the care that those patients who require charity care. You know, if the hospital is a 340B hospital, are those dollars truly going where they are supposed to go, and there again, and certainly not ever thinking that a hospital would be playing games, but I think if there is a wide and a very gray area there, I think that the hospital would utilize them as they need to,

and I think that might be something that we need to work on into the future.

And I will go back too to the cancer care in the hospital setting versus the outpatient or ambulatory care setting. This is something that I am very, very concerned about. I am very concerned about the cost issue with chemotherapy drugs, especially since the sequester went into effect. We have seen a number of cancer clinics that are in our communities basically closing their doors or being bought out by hospitals and many of them will cite that it has to do with, you know, basically the Affordable Care Act is an issue but then on top of it, the sequester has created a very difficult situation for them to continue in private practice, and in fact, I will add to that by saying that just in my hometown of Dunn, North Carolina, oncology practice was just purchased by a hospital, and now hospital care will be given at that clinic. The good news is, they will be there in Dunn. The bad news is, now the care is going to be much more costly.

So there again, it gets back to the issue of how do we justify that if that the patient receives the care in the

hospital, which is wonderful care, great care being provided by health care professionals, but then if they go to a more convenient area that they have come to appreciate and know and feel comfortable receiving their treatment, now that cost is going to go up simply because the hospital now owns that practice.

Mr. {Miller.} You have defined the problem extremely well. This is the way the Commission is thinking about it, and the only other thing I will say with respect to your comments is, the Commission has been on record as saying that, you know, the sequester is not a good policy and what we try to offer the committees of jurisdiction on a daily basis in every one of our reports are more thoughtful policies to get you where you need to be without having to do the across-the-board type of stuff.

Mrs. {Ellmers.} Well, thank you, Mr. Miller. I truly appreciate it, and thank you, Mr. Chairman. I yield back.

Mr. {Pitts.} The chair thanks the gentlelady.

All right. We will begin a second round. Dr. Burgess, do you have questions?

Dr. {Burgess.} Thank you, Mr. Chairman. So Mr. Miller,

we have been talking today about payment disparities across different sites of service, the inpatient hospital, outpatient department, ambulatory surgery centers and physician offices. Outpatient departments and ambulatory surgery centers have similar requirements to participate in the Medicare program and to be licensed at the state level, and both arguably provide high-quality care. Can you discuss the cost benefit of increasing payment rates in certain outpatient settings?

Mr. {Miller.} I am really sorry. There was some distraction over there, and I apologize.

Dr. {Burgess.} That is all right. Let us wait until it calms down.

All right. So we have various settings where can be administered. Ambulatory surgery centers, physician offices, outpatient departments, they all have similar requirements to participate in the Medicare program and to be licensed at the state level. All provide high-quality care. Can you discuss the cost and benefit of increasing payment rates in certain outpatient settings?

Mr. {Miller.} Increasing payment rates in certain

outpatient settings?

Dr. {Burgess.} Hospital outpatient department versus an ambulatory surgery center.

Mr. {Miller.} And the question is, should there be differences in the rate or--

Dr. {Burgess.} No. Are there differences in the rate, and then, what is the benefit that occurs because of the differences in the rate?

Mr. {Miller.} Okay. I am sorry. There are differences in the rate. I think a figure to carry around in your head is, there is about an 80 percent difference between the rate in an OPD and an ASC, just to focus on that for a second, and I think what the Commission explored, we made recommendations with respect to some services between a physician office and the OPD but over here on the ASC side, we also did some research where again we used some criteria, which I will take you through, but I understand your time is limited, where we tried to identify similar patients, you know, services that could safely be done in both settings and then said that there is the opportunity to lower the payment rate on the OPD side to the ASC rate. There were 12 services and in total it

is in the neighborhood of $500 to $600 million annually.

Dr. {Burgess.} And in this movement from a hospital to an outpatient setting, does that potentially free up the hospital time and space for use for other patients who have a greater degree of acuity who wouldn't be satisfactory to be serviced at an ambulatory surgery center?

Mr. {Miller.} Yes, I think that is our--in constructing the criteria, that is what we are trying to assure.

Dr. {Burgess.} Let me ask you this. In January of this year, the committee voted on recommendations around site neutrality for 66 ambulatory payment classifications. Is the Commission looking at other classifications or codes?

Mr. {Miller.} At least for the near term, the blocks that we have looked at are evaluation and management codes. The 66 APCs that you just mentioned, we have done analysis on that, and we have done analysis on 12 APC/OPD codes, and that is the exchange we just had one second or so ago. At the moment, this is kind of where we are. I am not 100 percent sure how much more we will do but the Commission sort of has to figure out what its cycle is going to be for the upcoming cycle. And so at the moment, this is what we have and this

is where we are. It would be hard for me to point to specific things that we are going to do beyond this.

Dr. {Burgess.} Mr. Chairman, thank you for the consideration. I will yield back to you.

Mr. {Pitts.} The chair recognizes Mr. Green 5 minutes for questions.

Mr. {Green.} Mr. Miller, I am concerned when we are discussing payment that we make sure to appropriately account for complexities and differences among patients. I believe if we move forward to reform the post-acute care setting, we should also be looking to make sure that we are appropriately adjusting provider payments to reflect those beneficiary risk scores. Can you discuss the issue: Do you believe risk adjustment is an appropriate issue to focus on?

Mr. {Miller.} Yes, and in all of our work, when we talk about bundling and we talk about differences, you know, creating either bundled payments or when we talk about moving towards a more unified post-acute care payment system or if we talk about assuming risk at more of population level, say an accountable care organization, we spend a lot of time talking about the need to measure differences in risk, and I

will say something a little more specific about that, and then also to make sure that we construct quality measures so you sort of backstop the patient in a couple of ways. You make sure that the payments that go out the door are adjusted in a way that they reflect the relative risk of I took this patient, you took that patient, and then we have quality metrics to sort of make sure that the patient is getting the kind of care that they need.

I think in the post-acute care setting, there are lots of discussions beyond things like diagnosis and the kinds of comorbidities, things like functional status, cognitive status, physical status, that thing of thing, which probably need to come into the mix in order to make the measurement more accurate, and we have got some discussion and focus on that in our work.

Mr. {Green.} You may have already answered that a little bit just now, but what steps do you take, for example, in developing a bundled payment would appropriately account for the differences? I think you just answered that one.

Mr. {Miller.} And again, I think it is this two-prong thing: try and get the risk adjustment as best as you can

get it and then have a set of quality metrics to stand by the beneficiary to make sure that they are getting the necessary care that they need.

Mr. {Green.} Okay. Thank you, Mr. Chairman. I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Dr. {Cassidy.} Hi, Mr. Miller. I am sorry for running in and out.

Mr. {Miller.} No problem.

Dr. {Cassidy.} So reading your testimony and listening to it, how much is--obviously is we are building through a hospital-based practice, I assume that is all Part A.

Mr. {Miller.} And we are talking about outpatient here, and so this is B.

Dr. {Cassidy.} So the facility fee would be Part A, wouldn't it, and the procedures oriented, so if they order an EKG and it is a hospital, it is still Part A, correct?

Mr. {Miller.} No, it is still B. I am sorry.

Dr. {Cassidy.} Oh, really?

Mr. {Miller.} Yes.

Dr. {Cassidy.} Okay. Well, that helps me.

Now, it also seems, though, in some of the testimony from others suggest that as we migrate towards these hospital-based practices, we are increasing costs for both Medicare and for the beneficiary.

Mr. {Miller.} That is right.

Dr. {Cassidy.} Now, if you have an accountable care organization, it obviously would increase the cost basis of their care if you have hospital-based services. Fair statement?

Mr. {Miller.} That is correct.

Dr. {Cassidy.} It almost seems that this is driving up the cost of health care, frankly. I mean, so if you will, it almost seems as if the more we emphasize or induce hospital-based accountable care organizations to acquire practices, i.e., it increases their profitability and increases their cost basis, we are inducing increase and expense both to beneficiaries and to the Medicare program.

Mr. {Miller.} That is correct.

Dr. {Cassidy.} So we actually have a set of policies

which are working in the exact wrong direction if our goal is to decrease cost to beneficiaries and to Medicare.

Mr. {Miller.} Yes, that is correct, and the only modification or addendum that I would say to that is, to the extent that you have prices for the same service on the outpatient side that look like this relative to the physician's office, you are creating an economic incentive to move in that direction. End of sentence. Next sentence. But of course, there are core hospital services--

Dr. {Cassidy.} Core, yes, I get that totally.

Mr. {Miller.} Okay.

Dr. {Cassidy.} I am a physician by the way.

Mr. {Miller.} We are saying the same thing.

Dr. {Cassidy.} Yes, absolutely, but that is, I think, lost in this debate, that we have created a law which is going to drive up cost. Just the behavioral economics of it is such that we are going to create these.

Let me ask you something else.

Mr. {Miller.} Yes, we are trying to make sure that it is not lost in the debate.

Dr. {Cassidy.} And I appreciate that. Thank you.

Now, also I am very interested in the 340B program, and you may decide that you may or may not wish to comment on this, but to what degree--I will read this, because it was prepared for me but I asked it to be. In the last few weeks, a report by the IMS on global oncology trends as well as other things shows that there is a different cost for Herceptin in different sites of service, that if you have a 340B hospital oncology-based program, that the delta between what they are, you know, charging and paying is such that it creates a competitive advantage relative to community oncologic services. Any comment upon this?

Mr. {Miller.} And I really apologize. I am not deep on that. There were a couple other questions on this. The only thing I can offer you is the Commission is aware of this issue and I have some work going on but it is very developmental at this stage. I haven't even taken it out in front of the Commission. So the only comfort I can give you is, we are not tone deaf. We understand that that is going on. We will start looking. We are looking at it.

Dr. {Cassidy.} Now, let me ask you then, with my minute and 30 left, if I go to the behavioral economics, there is a

sense in which if you put something at two-sided risk, you may mitigate the incentives to increase cost but let me ask, if you put somebody at two-sided risk, they get the upside but also swallow the downside, and they start off with a higher cost basis because they have acquired physicians' practices, particularly, say, orthopedics and hearts. I don't know this. I am asking. Going forward, if they begin to discharge those practices, those procedures to the outpatient setting, do they continue to get the profitability? Did you follow that?

Mr. {Miller.} I think I followed it. So I think you probably have a couple of questions in there, and just for purposes of discussion, let us frame it in the context of an accountable care organization. So if an accountable care organization is hospital-based and they have engaged in a lot of this, then arguably--and they get attributed patients in a way for purposes of this conversation occurs, then yes, arguably, they would have a higher base. And so that raises questions which are bigger than a minute 30 but the Commission has been talking about over time how the Medicare program should be looking at that phenomenon.

Dr. {Cassidy.} But going forward, if they then take this hospital-based practice and they sell it and it now becomes an outpatient and they begin to now that which was originally conceived at a higher cost basis they are now putting at a lower cost, do they consider--do they continue to get that delta or will the payments ratchet down?

Mr. {Miller.} It is theoretically possible that by moving people back, as you used in your example, to a lower cost setting, they could show a better performance. In other words--

Dr. {Cassidy.} So that would be an artificially conceived better performance? It would be merely arbitraging the regulations and the site of service?

Mr. {Miller.} That is right, but remember, we are talking about a very hypothetical situation.

Dr. {Cassidy.} Oh, man, it is not going to be hypothetical, Mr. Miller. I can promise you that.

Mr. {Miller.} And I didn't mean to imply that. There is two different, you know, ASC ACO programs, and exactly how the baselines are set get a little bit technical. But what I do want to leave you with is, the Commission is thinking

about these phenomena and how to think about setting those basements over time so these kinds of phenomena don't get away from the program. Theoretically, what you have set up there, yes, I see your point.

Dr. {Cassidy.} I yield back, and I thank you very much.

Mr. {Pitts.} The chair thanks the gentleman. That concludes the second round. Members will have follow-up questions. We will submit those to you in writing. We would ask you to please respond promptly.

Mr. {Miller.} Okay.

Mr. {Pitts.} Thank you very much, Mr. Miller. That includes the first panel. We will take a 2-minute break as the staff sets up for the second panel.

[Recess]

Mr. {Pitts.} We will reconvene. Everyone can take their seats. Our second panel, I will introduce in the order which they will speak. First, we have Ms. Barbara Gage, Managing Director and Economics Study Fellow, Engelberg Center for Health Care Reform, the Brookings Institute. We have Dr. Barry Brooks, Partner, Texas Oncology, and Chairman, Pharmacy and Therapeutics Committee, the U.S. Oncology

Network. We have work Dr. Reginald Coopwood, President and CEO of Regional Medical Center at Memphis; Dr. Steven Landers, President and CEO of Visiting Nurse Association Health Group; and finally, Mr. Peter Thomas, Coordinator, Coalition to Preserve Rehabilitation, and Principal at Powers, Pyles, Sutter and Verville.

Thank you all for coming. You will each have 5 minutes to summarize. Your written testimony will be made part of the record.

Ms. Gage, we will start with you. You are recognized for 5 minutes for your opening statement.

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^STATEMENTS OF BARBARA GAGE, MANAGING DIRECTOR, ENGELBERG CENTER FOR HEALTH CARE REFORM, THE BROOKINGS INSTITUTE; DR. BARRY BROOKS, CHAIRMAN, PHARMACY AND THERAPEUTICS COMMITTEE, THE U.S. ONCOLOGY INSTITUTE; DR. REGINALD W. COOPWOOD, PRESIDENT AND CEO, REGIONAL MEDICAL CENTER AT MEMPHIS; DR. STEVEN LANDERS, PRESIDENT AND CEO, VISITING NURSE ASSOCIATION HEALTH GROUP; AND PETER W. THOMAS, COORDINATOR, COALITION TO PRESERVE REHABILITATION, AND PRINCIPAL AT POWERS, PYLES, SUTTER AND VERVILLE

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^STATEMENT OF BARBARA GAGE

} Ms. {Gage.} Thank you, Chairman Pitts and distinguished members of the committee. I appreciate the opportunity to testify today on payment reforms for Medicare post-acute care. I have been studying these issues for a very long time and have led much of the research that underlies this work.

Post-acute care is a very important issue for the Medicare program. Almost 40 percent of all hospital discharges go on to post-acute care, so that is a key point

that I want to drive home. We heard a bit about the expenses associated with it.

Second, the patients who are in the acute care hospital for similar conditions we know are often discharged to different settings, and the information that we have leaves us a little unclear as to whether they are actually different in terms of their medical complexity or their functional complexity or cognitive, although some of our results suggest that is the case.

Third, the standardized assessments developed as part of the post-acute care payment reform demonstration showed that these patients could be measured consistently and reliably across post-acute and acute care settings, and once done, that would allow us to answer several questions, many of which came up today, with the same type of hospital patient discharged to alternative settings. We know that some of that varies by geographic area and the availability of beds but some of it may also vary by medical functional and cognitive status. Secondly, did the patient outcomes differ depending upon the site of care.

So why should patients be measured in a standard way?

That is a basic issue to answering these questions. As noted in your figures, you can see that almost one in five beneficiaries who are admitted to the hospital each year and about 40 percent are discharged from there into the post-acute care setting. Figure 1 is a little messy but it shows what a Medicare patient--their trajectory of care, and it underscores how these answers are not simple. People have different issues and attend different sites. So the sites include long-term care hospitals, inpatient rehab hospitals, skilled nursing facilities and home health agencies, all of which provide nursing and therapy services in their sites. Among the 37 percent of the PAC users who are discharged from the hospital to home health, 39 percent of them continued on to additional services, so an episode of care is not just one discharge, it is a continuation. The SNF admissions also tended to use multiple PAC services. Of the 42 percent who were discharged first to a NSF, 77 percent continued on to additional services, and about 23 percent of these cases return to the hospital while another 32 percent were discharged from the SNF to home health for additional services.

The probability and the type of post-acute care service used at hospital discharge can be partially explained by the reason for hospitalization, but as shown in figure 2, the types of cases that were most likely to use post-acute care were patients who had had joint replacements among the top five reasons for an admission to the hospital in Medicare, or stroke populations. However, the factors distinguishing what type of PAC setting would be used were less clear, and as you see on figure 2, the shares of these patients who were discharged to a SNF, 37 percent were home health with 36 percent with another 19 percent discharged to inpatient rehab, so it is not that there is a little bit of variation going on. Conversely, medical cases such as pneumonia and congestive heart failure were less likely to continue to post-acute care. Only about 33 percent of these cases go from the hospital to post-acute care, but when they went, they were most likely to go to SNF or home health, which have very different costs.

The probability of being readmitted to the hospital also varies by the reason for hospitalization, and as shown in figure 3, joint replacements may have a very small share who

are re-hospitalized in that 30-day window because we know technically they are healthier if they were strong enough for that surgery. But over 30 percent of the stroke, the pneumonia and the heart failure cases are readmitted during that window, and again, claims provide very little information to explain these differences. Additional information about health status is available from patient assessment data. In the Medicare program, assessment data is submitted in the inpatient rehab hospitals, through the MVS and the SNFs, through Oasis and the home health, and more recently, through the LTEC care in the long-term care hospital, and each of these assessment tools contain the same types of information including measures of their medical status, their functional status and their cognitive status as well as social support information collected by discharge planners. The same type of information is collected in the hospital as patients are admitted and managed through the stay. Despite these similarities in practices, few of the tools use the same items to measure the patient complexity. All are measuring primary and comorbid conditions, pressure ulcer staging, cognitive impairment, mobility and self-care

limitations, many of the things we have been talking about this morning, as well as documenting whether the patient will need assistance at discharge, whether they live alone, and the types of medications they are on but without using a common language to measure these characteristics, a patient's progression cannot be measured across the episode of care.

So findings from the post-acute care payment reform demonstration, this came up this morning, this was a major initiative mandated by Congress in the Deficit Reduction Act of 2005, which required CMS to develop standardized assessment items for use at hospital discharge and at admission and discharge to the post-acute care settings. The standardized assessment items were critical to allowing comparisons of the patient acuity, the differences in the complexity across settings, and more importantly, to answer these questions about whether outcomes differ across the setting. First you need to be able to know that you are looking at the same patient in terms of complexity.

Mr. {Pitts.} Could you begin to wrap up, please?

Ms. {Gage.} Yes. The care items were based on the science. They had the input of over 25 associations and each

of the clinical communities working with the post-acute care populations and were highly reliable in each of the different settings.

But what do these results tell us about payment policy? That one set of uniform assessment items can be used across acute and post-acute care settings. They were reliable in all the settings. They allowed the differences in patient severity to be documented.

A question about whether a standardized payment system can go into effect now based on the post-acute care payment reform data. We collected assessments on over 25,000 cases over 55,000 assessments in the data set, and while they were adequate for identifying key differences, key drivers of patients associated with one setting or another, there are small numbers of certain types of populations. So collecting the standardized data nationally for 2 years prior to actually finalizing payment systems will increase that sample size and allow you to have stronger numbers.

Why use standardized items across the acute and post-acute settings? Condition severity is independent of setting. Using standard language to measure it in each of

the three areas of health status will improve communication and allow data exchange across different IT systems. There is work underway right now by CMS and ONC working with the health IT communities to develop interoperable standards for the care assessment items, which will allow exchangeability even if one system is using a Mac and another an IBM product. CMS also provides the item specifications and the e-specifications, the training, the training materials to all providers who are required to submit assessment data, and the e-specifications are downloaded.

So why should the standardized assessments be collected at the hospitals? The hospitals already collect this type of information but they use different items to do so. A recent review by the American Hospital Association showed that the hospitals under the bundled payments and under the accountable care organizations were trying to predict readmissions but you couldn't compare differences across hospitals because they were all using their own systems. If you standardized the assessment items and include them, you can actually compare outcomes.

[The prepared statement of Ms. Gage follows:]

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Mr. {Pitts.} Thank you. The gentlelady's time is expired.

For the witnesses, we have a little series of lights on the table. It will start green. You will have 5 minutes. When it gets to red, that is 5 minutes, so if you can just keep that in mind and begin to wrap up at the red light.

Dr. Brooks, you are recognized for 5 minutes.

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^STATEMENT OF BARRY D. BROOKS

} Dr. {Brooks.} Chairman Pitts, Ranking Member Pallone, thank you for the opportunity to testify on behalf of U.S. Oncology and Community Oncology regarding site-of-payment reforms.

I am Barry Brooks, and for 32 years I have had the privilege of taking care of cancer patients in the community setting. Being an oncology is challenging but deeply rewarding, and I love it.

Americans enjoy the best cancer survival rates in the world. One reason we have the best cancer care is because the network of community clinics that provides state-of-the-art cancer care close to home. Yet in recent years, we have had a sharp decline in community-based cancer care, leaving patients with fewer options and more expensive medical bills. Thanks for recognizing one of the main drivers in the shift of care.

To be blunt, cancer care costs more in hospital outpatient departments and hospital-based care is growing by

leaps and bounds. Congressional action is needed to stem the shift of care and the resulting costs incurred to Medicare, taxpayers and patients.

I was pleased to hear Mark Miller's testimony today, and I am glad that MedPAC is weighing in on this important issue. Hospitals play a critical role in cancer care delivery, and I am not going to try to diminish that today, but instead highlight access and cost consequences of an environment that favors hospital-based outpatient care. This unlevel playing field should be fixed by any support of patient choice and access to affordable, quality cancer care.

In the current environment, hospital-based care enjoys numerous advantages over community clinics including up to 50 percent discounts on drugs for the 340B program, tax exemptions, Medicare reimbursement for uncollectable patient responsibilities, government payments for uncompensated care, tax-deductible private contributions, and the focus of today, higher payments for the same services.

In less than a decade, a third of outpatient cancer care has moved from the community to the hospital. Hundreds and hundreds of clinics have closed and hospitals are

aggressively buying up private practice oncology. Many times when this happens, patients see the same physicians, nurses and caregivers in the same offices. The only thing that changes, like mentioned by Representative Ellmers, is the name on the door and the amount charged to Medicare and the patients. In other cases, outlying clinics are consolidated to be closer to the main hospital campus, as mentioned by Representative Rogers. This results in increased travel and hassle for patients undergoing cancer treatment. Either way, patients fighting cancer are burdened by new barriers to access, either financial alone or both financial and geographic. A Milliman study finds that this costs Medicare $6,500 more per beneficiary each year, $623 million total each year, $650 more out of pocket for each senior cancer patient.

Why should we accept a system that requires the Nation's most vulnerable to pay more for the exact same service in a less convenient setting? Not only do hospitals charge more for the same services, their utilization and overall spending are higher too. An analysis of Medicare data by the Rand Company indicates hospitals spend 25 to 47 percent more on

chemotherapy and 42 to 68 patient more on chemotherapy administration. The latest CMS payment rules worsen our problem. The 2014 payment rate for the most common chemotherapy infusion is now 125 percent higher in the hospital than in the community. A recent IMS study calculated prices for 10 common chemotherapy treatments and found hospital charges for those treatments 189 percent more on average than an independent doctor's office. Sadly, they also show that patients who experience these higher out-of-pocket costs are more likely to discontinue treatment altogether.

We know the committee has supported policies to equalize E&M payments across care settings. We strongly support the efforts of Representatives Rogers and Matsui to take an urgent approach for oncology services. There is no reason for different payments for the same outpatient services to depend on whose name is on the door. As proven over the last decade, government-imposed market advantages will predictably lead to expansion and higher cost centers and corresponding reductions in patient access and increases in patient costs. Members of this committee have introduced and supported

legislation that enhances cancer patient access like H.R. 2869 that we are discussing today from Rogers and Matsui, H.R. 800, Whitfield, Representative Green and DeGette, and H.R. 1416 from Representative Ellmers and others. Over 30 members of this committee, 124 in all, have signed a letter to CMS questioning how the Administration handled sequestration cuts on our Medicare Part B drugs administered in our office. Given the current reality facing our community oncology offices, if these solutions are not enacted, by this time next year there will be fewer community oncology clinics and more patients will have to travel farther and pay more for the same services.

The world's best cancer care delivery system is struggling. We need your help.

Thank you for letting me testify today. I would be happy to answer questions when it is appropriate.

[The prepared statement of Dr. Brooks follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Coopwood 5 minutes for opening statement.

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^STATEMENT OF REGINALD W. COOPWOOD

} Dr. {Coopwood.} Good morning, Chairman Pitts, Mr. Green and--

Mr. {Pitts.} Can you poke the little button on there? Yes. Thank you.

Dr. {Coopwood.} Good morning. Chairman Pitts, Mr. Green and distinguished members of the subcommittee, I am Dr. Reginald Coopwood, President and CEO of Regional One Health in Memphis, Tennessee. I am here today on behalf of the American Hospital Association's 5,000 member hospitals, and I appreciate this opportunity to share with you and your colleagues the hospital field's perspective on site-neutral payment proposals.

Regional One Health, which serves a three-State area, includes a nationally acclaimed level I trauma center, a level III neonatal intensive care unit, the only American Burn Center-certified burn center in our region, and a high-risk obstetrical referral center. Annually, there are more than 100,000 outpatient visits to our health system. We have

four community primary care sites and more than 32 subspecialty services are provided in our outpatient facilities. Nearly one in four people in Memphis live in poverty, and the city has a very low health ranking.

Americans rely heavily on hospitals to provide 24/7 access to emergency care for all patients and to respond to every conceivable type of disaster. These roles are not specifically funded. Instead, they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care across various settings including hospital outpatient departments. Even though this is the case, some policymakers have endorsed proposals that would make payments for service provided in a hospital the same as when a service is provided in a physician's office or ambulatory surgery center. These proposals have a number of problems and would have devastating consequences for Medicare patients in the communities you represent.

First, it is important to know that hospitals are already losing money providing outpatient services to Medicare beneficiaries. The Medicare Payment Advisory

Commission data says that hospitals' outpatient Medicare margins are a negative 11.2 percent. To make matters worse, if site-neutral payment proposals under consideration by some policymakers were enacted, it would result in outpatient payment department Medicare margins of nearly negative 20 percent. This could force hospitals to curtail these vital outpatient services and threaten seniors' access to care.

Second, hospitals have additional financial burdens as compared to a physician's office. As was previously mentioned, this is due to the need to provide the community with 24/7 emergency capacity. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements. For example, hospitals must comply with EMTALA, a State hospital licensure requirement, the voluminous Medicare conditions of participation and Medicare cost reporting requirements, among others.

Finally, when compared to patients treated in physicians' offices, hospitals serve more medically complex patients as well as higher percentages of patients who are eligible for both Medicare and the Medicaid program and a higher percentage of disabled patients.

At Regional Medical Center, our hospital-based outpatient departments play an integral role in the health system's ability to fulfill our mission: to improve the health and well-being of the people we serve and to ensure that vulnerable patients have access to effective health care services which provide patients access to acute care services, a retail pharmacy that offers a sliding fee scale, medical interpretation services, surgical facilities, nutrition and diabetic care, as well as rehabilitation services. Providing these services has helped us reduce costly emergency department utilization, reduce hospital readmissions and improve care continuity for vulnerable patients and their health outcomes. The AHA has estimated that the proposed changes to hospital outpatient payments would reduce Medicare payments to my hospital, Regional One Health, by approximately $8 million over the next 10 years. Our ability to continue to improve the health status of our communities by ensuring that individuals have access to the right level of care at the right time in the right setting would diminish if those cuts were made. We also would have to evaluate our existing services as well as any plans to

expand our service capacity. This would disproportionately impact the most vulnerable and elderly patients that we serve.

Again, I appreciate your invitation to share the hospital's perspective on site-neutral payment policies with the committee. I urge you to exercise caution and not to propose any recommendations to Congress that would dramatically reduce payments to hospitals until a complete analysis and debate has occurred. Ensuring adequate payment for all services will allow hospitals to continue to provide access to care for all patients. Thank you.

[The prepared statement of Dr. Coopwood follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Landers 5 minutes for opening statement.

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^STATEMENT OF STEVEN LANDERS

} Dr. {Landers.} Chairman Pitts, Mr. Green, thank you so much for inviting me to testify today. My name is Steve Landers. I am a family doctor and geriatrician. My background is in home visitation for frail elders and people with disabilities and also in home health agency medical direction. I did my medical training at Case Western Reserve University in Cleveland, Ohio, and my geriatric training at Cleveland Clinic. I later went on to run Cleveland Clinic's home care and post-acute care programs, but the true honor, really the greatest honor of my career has been 2 years ago being able to leave my post at Cleveland Clinic and become a visiting nurse, and I am now the President and CEO of the Visiting Nurse Association Health Group in New Jersey. It is the Nation's second largest independent nonprofit home health organization in the country and the largest in New Jersey. We have been serving our communities for over 100 years.

I have, through my role as a physician, as a medical director, as an administrator, come to admire, frankly, if

not revere the work done by home and community health professionals, particularly nurses, aides, therapists, social workers. These individuals help people at the most desperate times in their lives. We know that those receiving Medicare home health services are sicker, older, more likely to be impoverished, more disabled, have higher disease burden than the general Medicare population. Home health services support these patients and families when they are really struggling, living in the shadows with things like Alzheimer's disease, multiple sclerosis, Parkinson's disease. They bring help to help people transition home from the hospital after a stroke, help patients learn to walk again, learn to eat again, support family caregivers in their often taxing job, sometimes 24/7 job, of helping their loved ones at home.

Home health care, it is essential to these families and these individuals, but as importantly, it is also essential for the future of our country. We have 70 million aging baby boomers that want to remain independent at home. This is our country's Sputnik moment for home care and elder care. We need to develop and improve our home care delivery system in

order to help these individuals meet their needs and also so that the programs, the Medicare program, Medicaid programs, don't suffer unnecessary financial burdens. Helping people stay home in a win-win where both the patients and families benefit and also the program sees savings.

The current Medicare home care program, it could be so much more. We can do so much more. The current model is limited by overly complex paperwork requirements. We have nurses and physicians spending an inordinate amount of time checking off boxes and filling out forms. The program has struggled with some integrity issues and fraud issues, particularly in aberrant geographies, and that needs to be fixed. There is confusing and unnecessarily limiting homebound requirements that make it difficult for certain people to get home care services. It doesn't make much clinical sense to me as a physician, and also there are opportunities around technology and care coordination that we are just not achieving yet.

And so that is why I am here to just share my enthusiasm and support for the work being done by Mr. McKinley and your committee on the bundling and coordinating post-acute care

initiative because this is a true innovation in how we look at post-acute care, and the flexibility and the removal of barriers to home care and the respect of patient choice that has been engendered in this proposal I think are worthy of commendation, and I am thankful to have the chance to be here to testify in relation to that initiative.

My former boss at Cleveland Clinic says that the future belongs to those who seize the opportunities created by innovation, and I believe that today that we are talking about a proposal that is an innovation in the Medicare program that can help us help more older Americans stay healthy at home in a sustainable way.

Thank you so much for the chance to come today.

[The prepared statement of Dr. Landers follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes Mr. Thomas 5 minutes for an opening statement.

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^STATEMENT OF PETER THOMAS

} Mr. {Thomas.} Thank you, Chairman Pitts, Congressman Green and members of the subcommittee. Today I speak on behalf of the consumer-led coalition called the Coalition to Preserve Rehabilitation, or the CPR Coalition. It is about 30 rehabilitation and disability organizations, and it is run by a steering committee of the Center for Medicare Advocacy, the Brain Injury Association of America, the United Spinal Association, the National Multiple Sclerosis Association and the Christopher and Dana Reeve Foundation.

My testimony today focuses on post-acute care and the importance of preserving access to rehabilitation, timely, intensive and coordinated rehabilitation care, in the context of site-neutral payment proposals and bundling proposals.

First, I am worried about the importance of rehabilitation. The Coalition believes that rehabilitation is truly the lynchpin to improving health, function and independence of Medicare beneficiaries after an illness or an injury, a disability or a chronic condition. But these

settings are not all the same, and in fact, the outcomes in these different settings are quite different, and I am happy to say that we are beginning to get new data that actually demonstrates this rather than just the intuitive sense that that is the case.

Just a quick personal word. Like many Americans, I have personal experience with rehabilitation. When I was 10 years old, I spent about 2-1/2 months in a rehabilitation hospital, Craig Rehab Hospital in Denver, Colorado, following a car accident where I lost my legs below the knees, and proceeded to have a goal of walking into my fifth-grade class, which I did, and since then have used 13 different sets of artificial limbs over the past 40 years and have had a real front-row seat in what a good rehabilitation program and what good prosthetic care really means. All Medicare beneficiaries should have the same access that I did to that care.

Under Medicare PAC reform proposals, both site neutrality and bundling, all Medicare patients should have access to the right level of intensity coordination of rehabilitation in the right setting and at the right time and on a timely basis, and of course, that is easier said than

done. We believe that any legislative changes to the post-acute care environment on these issues should not have the effect of restricting access to rehabilitation care and should avoid proposals that will lead to a reduction in Medicare rehab benefits or that erect policy barriers that will affect beneficiaries by essentially channeling them into settings of care that are less than what they need in terms of their individual or medical rehab benefits.

In terms of the SNF/INF site-neutral payment proposal that has been proposed in the last few budgets from the President as well as MedPAC, the Coalition opposes this proposal. We believe this is little more than an outright financial disincentive for inpatient rehab hospitals and unit to accept certain beneficiaries based solely on the patient's diagnosis and not based on their individual needs and rehabilitation and functional requirements.

And so while that is the case, we do not necessarily oppose bundling. In fact, recognize the different silos of care that often lead to inefficient care in the post-acute care environment and we favor well-developed bundling proposals that are based on sound evidence and are linked to

quality measures and to risk-adjusted payments so that those savings are not achieved by essentially stinting on patient care. And with due respect to some of the things that I have heard this morning, we do believe that further study is needed in this area. This is a very complex area and it impacts very vulnerable Medicare beneficiaries.

In terms of the Bundling and Coordination Post-Acute Care Act of 2014, we believe that this is a model--bundling is a model again that we do not oppose--but we think that especially to protect vulnerable beneficiaries, there needs to be some improvements, and we will just quickly tick off a few of those. Number one, we have great concerns about the bundle being held by an acute care hospital or an insurance company. We believe that PAC providers, people that are in the post-acute setting who understand rehabilitation and know what the patients' needs and what they will need in terms of services should be the bundle holder in those instances. There is a concept known as the continuing care hospital pilot, which is mandated by law that CMS implemented and inexplicably CMS has not yet moved forward with that pilot. We encourage them to do so. A rehabilitation physician

should be directing the care in a bundled payment system.

Device exemptions should apply. You should not have prosthetics or orthotics, durable medical equipment that are of a customized nature included in the bundle because we have got evidence based on the SNF PPS many years ago that those kinds of devices are simply not provided to beneficiaries under a bundled payment system. They are either delayed or they are denied completely. And there are certain vulnerable patient populations such as traumatic brain injury, spinal cord injury and other conditions that we do not recommend bundling, at least in the initial phases of implementation.

Risk adjustment and quality measures are obviously the most important to make sure that people are not underserved under bundled systems, and the rest of the detail on that is in my testimony. Thank you.

[The prepared statement of Mr. Thomas follows:]

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Mr. {Pitts.} The chair thanks the gentleman. Thanks to all the witnesses for their opening statements. I will begin questioning and recognize myself 5 minutes for that purpose.

Dr. Coopwood, in your written testimony, you suggest that the facility fees disparity between physician offices and hospital outpatient settings for cancer treatment is justified by the need to maintain ``standby capacity that allow hospitals to respond to emergencies ranging from multivehicle car chases to hurricanes and terrorist attacks.'' I would respectfully ask how this is relevant to the way Medicare pays for chemotherapy.

Dr. {Coopwood.} Thank you. The way the hospital system's cost structure is built into the payment, we have to--there are many things that we have to do that private physician offices do not have to do. I am a former surgeon and ran a three-member group, and we had a very lean office in order to be able to economically make that system work, but in operating a hospital and a hospital system, the costs associated with 24-hour emergency care, the costs associated with the accreditation bodies, just to have a hospital-based

clinic in order to qualify for Medicare patients, we have to be certified by Joint Commission. That puts a significant amount of burden and cost into the system that a private physician does not have to have.

So all of those things that you mentioned built into the actual cost to operate a hospital-based clinic, they are not directly tied to the chemotherapeutic administration but it is part of the infrastructure costs that this facility must bear in order to deliver that high level of care.

Mr. {Pitts.} Well, would you respond to this question? Is it fair that cancer patients face higher out-of-pocket costs for the same care when physician offices are bought by hospitals?

Dr. {Coopwood.} And I guess ``fair'' is the key word in your question. When hospitals acquire physician practices, and there are many drivers as to why that happens--it is not just to get a higher payment--there are physicians in oncology practices that are coming to hospitals to acquire them because of the economics of trying to run private practice, the economics of trying to get an electric medical record, the difficulties in having continuity of care and

wanting to be part of a system. So there are many drivers as to why these practices are coming into the hospital under the hospital's continuum. Because of that transition from a less expensive-run entity into a more expensive or higher-cost entity, there is where the increase in reimbursement comes in to help pay for that higher infrastructure.

Mr. {Pitts.} Well, are there any payment reforms or site-of-service reforms that you would support that might reduce payments to hospitals?

Dr. {Coopwood.} I think there are--in my testimony, we, we being American Hospital Association, want to be a part of the conversation as we look at these payment proposals. I think that we don't want to do in such a way that it jeopardizes the hospitals and puts hospitals at risk because if we do drastic measures in a way, it will put risk to those emergency services and all that because, as I described in my testimony, just changing it from a facility-based payment to a private office payment adds $8 million to my hospital on a $300 million cost. I mean, that is significant.

Mr. {Pitts.} Dr. Landers, in your written testimony you observe that care is much cheaper to deliver in home-based

than institutional settings. In long-term care, some worry that a shift to home-based care ends up being more expensive due to more claimants coming out of the woodwork. Is this also the case for post-acute care?

Dr. {Landers.} Thanks for your question, Chairman. As you correctly point out, care at home tends to be less expensive than facility-based care. For example, a month of post-acute care at home for a Medicare beneficiary is costing the program roughly $1,200 to $1,500 for that month versus in a subacute facility $12,000 to $15,000 for that same month of care, and we know from the variation that has been referenced earlier in this committee and from some of the research that has been submitted that there are many instances when the home is a clinically appropriate setting and we can get people home as an alternative to institutional care. So one of the opportunities in the bundled payment initiatives is to appropriately use home care, which is lower cost, often desired more as a substitute for unnecessary facility care, and not just clinically unnecessary. Patients and families don't want to be unnecessarily pushed into facility-based care, so I see this as an opportunity to save money, not to

spend more.

Mr. {Pitts.} The chair thanks the gentleman. My time is expired. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. {Green.} Thank you, Mr. Chairman.

Dr. Brooks, for the past few Congresses, I have teamed up with our Kentucky colleague, Congressman Ed Whitfield, in introducing legislation to fix a flaw in the Medicare reimbursement formula without impacting providers. This legislation is called the Prompt Pay Bill, H.R. 800, as you mentioned in your testimony, and would ensure that CMS no longer includes prompt pay discount when reimbursing providers.

Dr. Brooks, as we talked today about factors that are causing patients to be shifted out of the community settings to more expensive settings, what impact do you think passage of this bill would have on helping prevent this shift in care?

Dr. {Brooks.} Well, the prompt pay--thank you, Representative. I appreciate your bringing it up. It would help us a great deal. It would true up the legislative

intent of the original legislation and right now we are not given that almost 2 percent on the Medicare service fee for managing chemotherapy drugs, and it would, in my opinion, metaphorically say take a lot of community practices off of life support, and if we were to pair it with the Rogers-Matsui bill and the Ellmers bill, we could restore vitality to community oncology, but prompt pay would go a long way standing on its own.

Mr. {Green.} Do you think addressing that formula flaw would benefit both patients and ultimately the taxpayers on the amount that is being reimbursed?

Dr. {Brooks.} Absolutely. As I mentioned in my testimony, the most recent data suggests that the costs in the hospital outpatient department are almost triple what they are in our facilities, 189 percent in the IMS study. Certainly patients would benefit, because the copays would be so much less in that setting, and our practices tend to be located closer to a patient's home so that the travel is less and the patient's out-of-pocket costs are much less. Medicare gets no value from hospital-based outpatient cancer care. The patients get no value from hospital-based

outpatient care.

Mr. {Green.} And have there been studies that show between hospital-based and outpatient facilities on the quality of the care or the results?

Dr. {Brooks.} The care was assessed primarily for equality of the type of patient. There are no quality measures within those studies but there is no reason to think that the type of patients between the two facilities is any different whatsoever, and it is mostly just a cost and reimbursement setting issue. It benefits the patients to be in our clinics.

Mr. {Green.} Thank you.

Ms. Gage, under the current Medicare payment system, hospitals are not provided any financial incentives to refer patients to the most efficient or effective setting so that patients receive the most optimal care at the lowest cost. Whether a patient goes to a home health agency or skilled nursing facility, for example, depends more on the availability in the post-acute care setting in the local market, patient and family preferences or financial relationships between providers.

Ms. Gage, since patients access post-acute care after a stay in the hospital, how can we best encourage hospitals to help ensure patients receive care at the right setting after a hospital stay?

Ms. {Gage.} Thank you for the question. Many of the-- one way to address it is to keep the hospitals accountable for the post-discharge time period as is currently done with the readmissions policy in the fee-for-service program. Giving the hospitals accountability for the continuing care and the coordination with the subsequent providers is critical to forming the team that is needed to address the patient needs.

Mr. {Green.} I know we are doing some of that now because of the Affordable Care Act, so do you see any recent evidence that that is occurring?

Ms. {Gage.} I do, as another hat that I wear is evaluating the bundled payment initiatives, and there is much more discussion in the hospitals that are participating in bundles to be communicating with the post-acute care setting and following the patient through that 90-day period and actually giving information around the entire caregiving

team. It has led to reduced readmissions but there are two types of patients. There are the medical patients and the rehab patients, and in the rehab patients, you have fewer measures of outcomes than you have with the medical community except for functional change for those who have acute needs.

Mr. {Green.} That brings up my next question.

Mr. Thomas, there is resounding consensus that as part of any payment reform, robust, meaningful quality measures must be available. What challenges are there in measuring these quality outcomes of Medicare beneficiaries who receive these post-acute care services again in various settings?

Mr. {Thomas.} Thank you very much for the question. Well, I would say first that the quality metrics across the different settings, the primary areas of post-acute care are not uniform and so it is very difficult to measure quality across different settings with different systems. I think that there is a lack of functional measures but in particular quality-of-life measures, and it is very important that after a post-acute care stay, it is not necessarily the range of motion that a person is able to achieve in their rehabilitation through their rehabilitation stay, it is

whether that person can dress themselves again or whether they can play golf or whether they can go back to work if that is appropriate. It is returning to life roles, and that is--those kinds of measures, there are data sets that measure those kinds of things but that is where the consumer groups or disability groups would like to see much more emphasis on measuring those kinds of things of returning back to community life and living as independently as possible, and if you can't do that as a result of a particular post-acute care stay because you weren't set to the proper or the more intense setting of care with that set of services that you really need to meet your individual and unique needs, then you are really not getting all you can out of the Medicare program, and that would be a real shame.

Mr. {Green.} Thank you, Mr. Chairman, and we will probably have some other follow-up questions of the panel. Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Ms. Ellmers, 5 minutes for questions.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you

to our panel for being here today. These are issues that are very, very important to me, having been a nurse for over 20 years prior to coming to Congress, and again, also, my husband being a general surgeon and actually having had his own solo practice and now has joined a practice owned by a hospital, and I would say to that point, there are significant economic factors that play into that, especially now with the Affordable Care Act, and many of the costs that our physicians in private practice are faced with, and we understand the hospitals are also faced with many of those same situations, and I think it is important to point out and recognize that individual patient offices, small businesses are faced with many, many issues of overhead, Dr. Coopwood, you mentioned electronic medical records being one of them, great cost to individuals and practitioners, and those are definitely hurdles.

But on that, I do want to talk--Dr. Brooks, you had mentioned, and I would like to talk a little bit about my bill, H.R. 1416, addressing the sequester cuts to Medicare Part B drugs as a result, as we know, of the sequester cut. Unfortunately, now, it has been over a year since I

introduced that bill, and we do have a number of cosponsors. However, it is one of those things where information has to be gathered as we move along, and unfortunately, the results are playing out. There are many community cancer settings that are closing their doors or are being bought up by hospital practices. In fact, I had mentioned this in the previous panel with Mr. Miller, that a practice in my hometown that has, you know, been a 30-year oncology practice, you know, private practice has now been purchased by one of the hospitals. Now those same patients, although they will be able to receive the care in that same clinic, will be paying more money, and I do think that this is significant and something that we must draw attention to.

So I guess my question to you very simply and very plainly is, if we were to pass H.R. 1416--and again, when I talk about Medicare Part B drugs, it is not just chemotherapy drugs. We are talking about other drugs that any physician would have to--is responsible for administering in the outpatient setting. Would there be a cost savings to that patient and would there be a cost savings to Medicare overall?

Dr. {Brooks.} If we were to pass 1416, and right now, for those of you who are not familiar with the perverse interpretation of CMS on our Part B payments, they decreased our service fee for managing chemotherapy and oncology offices not by 2 percent as we anticipated but by 28 percent when one does all the calculations because they included the entire cost of the drug. And so our service fee was decreased by 28 percent. This has caused great hardship in the oncology communities, and even with my own U.S. Oncology Network, we have practices now in peril, and prior to sequestration, really those practices were fine. So this additional blow on top of the lack of prompt pay relief and the lack of site neutrality payments--I mean, CMS decreased our reimbursement for chemotherapy infusion again this year--those triple burdens are causing practices even in our very robust, efficient network to be financially imperiled, and if we got 1416 passed, we got relief from that, that would put us back just like Representative Green's question, it would take us off of life support. Right now, we are impoverished and barely paying the light bills.

Mrs. {Ellmers.} Thank you, Dr. Brooks.

And Dr. Landers, I do have a question for you. I am a huge proponent of home care services. I think we are helping our patients, especially our Medicare patients, our most vulnerable, to stay out of the hospital setting where they can be at home receiving care. One of the other issues, as we know, and I am sure you are aware as well, and I just want to get your verification on this. We are talking about a patient population of Medicare patients who are largely women and we are also talking about an employee population that is by and large women as well. You know, we are faced with this question here in Washington all the time: how can we empower women and what is the true war on women. How do you feel about that situation?

Dr. {Landers.} Congresswoman, thank you for the question. In my experience, one of the best things about my work has been with many nurses and patients and family caregivers, quite frankly in home care most of them have been women, and if you look at the Affordable Care Act re-basing cuts that are sort of just across-the-board, non-risk adjusted, non-outcomes-based cuts, they are hurting women disproportionately because that is where--that is who is

involved with home care by and large, our employees, our nurses, our therapists, our social workers, our aides are disproportionately women. The patients tend to be women and also we can't forget family caregivers. Although some of us men chip in every once in a while, the women nationally are bearing the brunt of the family caregiving responsibilities and home care is their support and their lifeline. So I am glad that you brought that up, and I think it is important that we are focused on payment reform and innovation based on value rather than these across-the-board disproportionate cuts on things that hurt a lot of people including a lot of women.

Mrs. {Ellmers.} Thank you, Dr. Landers, and thank you, Mr. Chairman, for indulging me and letting me go over a little bit.

Mr. {Pitts.} That is all right. Thank you. The chair thanks the gentlelady.

We are voting. We have got 12 minutes left in the vote. We will go to Mr. Rogers 5 minutes for questions.

Mr. {Rogers.} Thank you very much, Mr. Chairman.

Mr. Brooks, can you tell me in your experience as a

community oncologist what this shift that we talked about earlier of the closure of so many, 241, I think, practices around the country, what impact does that have on a patient that is in one of those 241 closed facilities?

Dr. {Brooks.} Thank you for the question. I have had the opportunity to talk to some of my friends who have been acquired by the hospital, and I have been curious about some of the hospital assertions that licensing requirements and other things are more onerous under that situation. I have not been able to discern any additional licensing requirements that were required for these offices that were taken over, but one of my friends in another State, I talked to him recently, and when he transitioned his patients who were on chemotherapy from his bills to the hospital bills, he had several patients come in with their bills and say what is this, because the bills were over 100 percent more than what he had charged them from his own thing, and the door had changed names but the nurse was the same, the doctor was the same, the office was the same, and the patients were confronting him and he had substantial angst, but in his defense, their practice was in peril financially. They were

not doing well, and they could have hung on a while longer but they were on an intolerable course based on, in his case, mostly sequestration.

So there have been serious displacements among my colleagues and they are not happy to go to the hospital. They would prefer to be independent but in many cases want to continue to take care of their cancer patients and that was their only option.

Mr. {Rogers.} And what about those that have been closed? I mean, we talked a lot of numbers. I could talk to you all day long about the cost disparities or not, the payment disparities or not, but a patient is in that mix and in that number somewhere. So my center closes. What happens? If you are an average patient there, you are in the middle of some radiation treatment that is not an easy process to go through, talk about the patient, Doctor, if you would.

Dr. {Brooks.} Oh, the patients are at the center of our concern here, and if our centers in rural Texas close, we are the only providers. Hospitals are always talking about being the only provider but we are the only provider for cancer

care in most of rural Texas, and if our center, say, in Paris, Texas, where we are 70 percent government pay, if that center were to be deemed by our organization to be no longer financially viable and we had to close that, those patients would have to drive more than 100 miles each way for a radiation center.

Mr. {Rogers.} And what does that mean? If I am a patient undergoing treatment, what does that 100 miles mean to me?

Dr. {Brooks.} Well, Representative Rogers, if you are frail enough, you can't do it. You can't continue 100-mile commute every day for five weeks, and it is an issue that comes up for us all the time. Frail, elderly patients cannot make long commutes. They are not able to. And they choose to discontinue treatment and not get adequate care.

Mr. {Rogers.} And I have heard examples and I am sure you have heard examples of people who are choosing not to continue care or treatment because of the distance to travel.

Dr. {Brooks.} Yes, sir.

Mr. {Rogers.} Well, that is one way to save money, I guess.

Dr. {Brooks.} Yes, sir, it is a perverse way to save money, but it is true that patients discontinue therapy because of travel burdens, particularly in States that are spread out like Texas.

Mr. {Rogers.} My frustration with this is exactly what you said, so one day the shade goes down and it is whatever the rate is, the next day it opens up under this new contract because a hospital-affiliated center now and the price goes up, and I think the number we heard was roughly 20 percent on average across all of the specialties. What is the difference in care that that person gets from the day that the shade goes down until the day the shade goes up? What is the difference in care?

Dr. {Brooks.} There is no measurable added value for those patients, and there is no measurable added benefit to Medicare for transferring the care.

Mr. {Rogers.} Are there more regulations they have to follow?

Dr. {Brooks.} I have actually--the hospitals assert that. I have looked into that, and I have asked my friends who have been acquired by the hospital and have not been able

to find any additional licensure requirements or other regulatory burdens that they had to bear after hospital acquisition. I sought that information and was not able to find any.

Mr. {Rogers.} Again, Mr. Chairman, I think we would all be remiss in our duties if we stand by and allow one more cancer patient not to be able to make travel, select not to get treatment or their costs go up so prohibitively they can't continue treatment. Shame on all of us if we can't pull this together pretty soon so that we don't lose any more of these centers. I think it is awful important we deal with this issue soon. Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman. There is 6 minutes left to vote on the floor. Dr. Burgess, you are recognized for 5 minutes.

Dr. {Burgess.} Thank you, Mr. Chairman, and again, I want to thank our panel. I appreciate you being with us today and your forbearance through what has been a long morning.

Dr. Brooks, as you were answering Mr. Rogers' question, I think he asked specifically about someone who was receiving

radiation therapy, but a chemotherapy patient then has that 100-, 120-mile drive home, I can't quite do the calculation on how many sublingual Zofran may have to be consumed on that drive but you are adding a significant burden to the clinical course of that patient, are you not?

Dr. {Brooks.} Yes. Travel is a burden when you are ill. I mean, any of us who have just had the flu and tried to drive to your local doctor's office understand how crummy you feel in a reasonable commute. But in very long commutes for people that are chronically and acutely ill, it is intolerable, and people do select to discontinue care for that reason.

Dr. {Burgess.} I am old enough to remember when your partners came to our community hospital, and we were grateful for that, to have the services for our patients, but I also remember not being able to electively hospitalize a patient on a Tuesday because that is the day your partners filled the hospital up with their chemotherapy patients, so it was also a great day when they opened their own center and now the chemotherapy was administered as an outpatient. So are we in fact driving back the other way? Is hospital bed

availability going to become an issue because of the occupancy of those beds with chemotherapy patients?

Dr. {Brooks.} Well, it is a little different these days. We don't actually put people in inpatient beds like we did--I actually didn't know you were that old. But in my youth as an oncologist, we did in fact hospitalize patients, put them in hospital beds. Nowadays, most hospitals have outpatient treatment departments that look quite similar to our physician offices, and they do not occupy inpatient beds in most cases. So that is not a concern per se.

But the migration, like Mark Miller said earlier, from the lower cost, more efficient to the higher cost, less efficient because of the economic incentive, and that is what we are looking at here.

Dr. {Burgess.} Yes, and I actually tried to encourage him to be a little bit more vocal about that, and I wasn't able to draw it out of him, so I appreciate your articulating that concept because I think it is important.

I used to be a student of medical irony but now I have kind of branched out. I just cannot tell you the frustration of dealing with the Centers for Medicare and Medicare

Services trying to get them to calculate a correct arithmetic equation of the 2 percent reduction in the sequester of ASP Plus 6, and this was the subject of a letter. We had a lot of people that signed on. To their credit, they wrote me back but they wrote me back to me indicating that they didn't understand how to do simple arithmetic. ASP Plus 6, for people who don't understand what that is, that means you take the average sales price of, in this case, a drug, and you add 6 percent, which arguably should cover the cost of storage, administration, your staff's time, the IV tubing, all of the things that are connected with administering that drug. I recognize that the plus 6 doesn't really cover that, but still, in theory, the plus 6 should cover that.

But it makes no sense if you are going to apply an across-the-board reduction with the sequester of 2 percent. You would never begin with the ASP part of that equation. The ASP part of that equation is a fixed cost. That is a direct cost. That is like saying well, we are going to reduce--someone is going to come in and reduce your light bill by 2 percent because Medicare is cutting you 2 percent. They are not going to do that. Your electricity charge for

keeping the drug refrigerated, your carrying charge is all the same. It has not been impacted. No one has cut you a break because Medicare is reducing your reimbursement.

So I continue to be frustrated with that. I continue to try to educate our good friends over at the agency. So far, I have not been successful, but like you, I fear that the consequence of this error in calculation is going to be a big driver. Again, you so well articulated what the actual reduction means to your clinic and your office and how hard it will be to keep your doors open.

Let me just ask one last thing before we finish up and I have to go vote. The issue of EMTALA came up, and Dr. Coopwood, I think you referenced that, that this is of course something that the hospital bears, but doctors bear it too. I mean, EMTALA applies to both providers that are both physicians and hospitals. So the question on the EMTALA mandate actually affects both physicians and hospitals. Is that not correct?

Dr. {Coopwood.} I am really just aware of the responsibility of a hospital's role in EMTALA. Someone shows up on their perimeter property, they have a responsibility to

treat them and at the minimum stabilize them. I am not sure if that extension goes into the physician's office practice because they are not obligated to see everyone who presents to them as a hospital is obligated to see everyone in emergency situations.

Dr. {Burgess.} Let me elaborate on that just a little bit, because as a member of the hospital staff of your hospital, if your emergency room doctor calls me because of a woman in labor, for example, I got to show up. I have got to show up within 30 minutes or a $50,000 fine comes my way. So I would just argue that it does affect the doctors as well as the hospitals. It might not affect the bottom line in our office practice, but as far as the taking of our professional services, it still occurs under EMTALA as it does for you.

Dr. {Coopwood.} Absolutely.

Dr. {Burgess.} Mr. Chairman, I know we have a vote on.

I want to thank our panel again. It has been very informative. I have got some questions I am going to submit for the record. Thank you for being here, and I will yield back.

Mr. {Pitts.} The chair thanks the gentleman.

There is no time left on the clock for voting, so I urge members to get over to vote. We still have some 250 people who haven't voted.

Thank you for your responses, for the questions. Some additional questions we will send to you in writing. We ask that you please respond promptly. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to please respond promptly. Members should submit their questions by the close of business on Wednesday, June 4th.

A very good hearing. Thank you so much for sharing your expertise with us. Without objection, the subcommittee hearing is adjourned.

[Whereupon, at 12:48 p.m., the subcommittee was adjourned.]